NATIONAL RURAL HEALTH RESOURCE CENTER

Optimizing Ambulatory Healthcare for the 21st Century

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DRCHSD Value-Based Care Series

Sessions:

- May 27, 2021 – Successful Models to Engage Providers in Value-Based Care (VBC)
- June 3, 2021 - Best Practices to Work with Community Partners on Population Health Initiatives

Pre-Polling Questions

I am ____ in my understanding of how payors and health plans define quality in an ambulatory setting.

I am ____ in my understanding of how commercial payors incentivize hospitals based on care measures.

Introduction

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BURROUGHS
HEALTHCARE CONSULTING NETWORK

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Disclosure of Relevant Financial Relationships

No financial relationships to disclose

Like every other industry in the 21st century, Healthcare is becoming….

1. **Digitized:** business intelligence tools with clinical/cost analytics powered by an enterprise data warehouse and supported by decision support tools
2. **Standardized:** elimination of non-value added clinical/operational variation and waste (1000%/65%)
3. **Commoditized:** the race to the bottom to provide high quality/low-cost services in new ways
4. **Globalized:** we are in competition with the world

Value Migration in the New Ecosystem (The Obama Care Index)

- Inpatient services (40%)
- Inpatient ancillaries/elective procedures (50%)
- Retail diagnostics with 50% fall in price (85%)
- Traditional primary care practice (60%)
- Retail, mobile, social app options (85%)
- Clinical/business analytics (>400%)
- Retail pharmacy management/analytics (140%)
- Next generation diagnostic wireless tools (>1000%)
- Genomics/protenomics/microbiomics (>1000%)
- Traditional Healthcare System (40%)

New Ecosystem ($5T market)

Source: Oliver Wyman (2014)

How do Payers and Health Plans Define "Quality" in an Ambulatory Based Setting?

Healthcare Effectiveness Data and Information Set (HEDIS MEASURES) developed by NCQA for CMS, Commercial Payers, and used by >90% of Health Plans: 91 measures across seven domains of care

1. Effectiveness of Care (52 measures)
2. Access/Availability of Care (6 measures)
3. Experience of Care (4 measures)
4. Utilization and Risk Adjusted Utilization (15 measures)
5. Relative Resource Use (5 measures)
6. Health Plan Descriptive Information (7 measures)
7. Measures Collected using Electronic Clinical Data Systems (2 measures)

Types of Effectiveness of Care Measures:

- Immunizations
- Screenings
- Appropriate testing and medication management
- Appropriate follow up and monitoring
- Good compliance with recommended treatments
- Avoidance of non-recommended diagnostic testing or treatment (excessive testing or procedures)
- Avoidance of potentially harmful medications
- Core measures (outside of inpatient settings)
- Smoking cessation

Types of Access and Availability of Care Measures:

- Primary care
- Dental care
- Alcohol and Drug rehabilitation
- Pre- and Post-natal care
- Call answer timeliness

Types of Experience of Care Measures:

Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures for both adults and children developed by AHRQ for CMS, NCQA, and Payers/Health Plans for:

- Hospitals
- Clinician groups
- Hospice
- Ambulatory surgery

Types of Utilization and Risk-Adjusted Utilization Measures:

- Frequency of pre/post natal, well child, health maintenance visits
- Frequency of ED and inpatient visits/care
- Mental health
- Drug and alcohol rehabilitation
- Antibiotic use
- Hospitalization for preventable complications

Types of Relative Resource Use Measures:

Excessive use of ED and inpatient setting for individuals with:

- Diabetes
- Cardiovascular conditions
- Hypertension
- COPD
- Asthma

Types of Health Plan Descriptive Measures:

- Board certification of physicians and practitioners
- Diversity of membership, language, cultural background
- Weeks of pregnancy at the time of enrollment
- Membership by State, service line, and totals

Types of Electronic Clinical Data Measures:

Use of PHQ-9 to monitor for depression (relapse and remission in adolescents and adults)

PHQ-9 is an instrument for screening, diagnosing, measuring monitoring the severity of depression utilizing DSM-IV diagnostic criteria.

How do Commercial Payers Incentivize Practices and Organizations Based Upon these Measures?

Blue Cross and Blue Shield of Tennessee Value Based Managed Care Plans:

1. Metrics are collaboratively chosen by practitioners, management and payers based upon practice profile
2. Metrics are scored from 1-5 stars based upon negotiated benchmarks
3. Each star is valued at $2 per member per month
4. Impact on each practice is potentially $250,000-$500,000 (assuming a 2,500-5,000 panel)

Thus, Hospitals will…

- Reduce capacity to focus on the 'sick minority' who require specialized inpatient services
- Form regional 'hub-hub' networks to keep patients in as low a cost setting as possible
- Transfer most of its stable routine work to lower cost outpatient settings (and receive ambulatory payments if they don't)
- Facilitating end of life care in a home-based environment
- Develop innovative alternative approaches to preserve margin in a significantly lower globalized cost structure (50%-90%)

Hence, the continued growth and expansion of the ambulatory healthcare sector in new and innovative ways

Three Major Reasons why Primary Care Practices Lose Money:

I. **Wrong person doing the wrong job**

II. **Lack of professional documentation/coding at the point of care**

III. **Lack of appropriate risk-severity adjustment**

I. Assign the Right Person to the Right Job:

Southeast Georgia Diagnostic and Prevention Center, Vidalia, Georgia:

A. Two investor physicians providing executive oversight of a wellness and diagnostic 'focused factory'

B. Two investor APPs (PAs) oversee two dozen RNs/LPNs performing two hour 'wellness examinations' per > 190 clinical protocols developed by physicians

C. Two dozen support personnel providing all technology and clinical/non-clinical documentation functions

II. Add a Qualified Clinical Scribe to your Team!

Southeast Georgia Diagnostic and Prevention Center, Vidalia, Georgia:

A. Imbed diagnostic and documentation codes into software support

B. Perform regular audits to ensure that documentation accurately reflects actual acuity and complexity

C. Ensure that clinical scribes are certified coders and have a comprehensive understanding of hierarchical condition categories (HCCs) and other risk/severity adjustment methodologies

III. Ensure Robust Risk and Severity Adjustment on Each and Every Patient!

A. "Pay for value" requires robust risk and severity adjustment no matter what the public or private payer!

B. Risk/severity = primary diagnosis + all co-morbidities + 'non-clinical' determinants of care

C. Risk-adjustment = next year's 'budget' (e.g., cost report)- examples: 50% of Medicare Part B QRUR performance reports, 30% of MACRA's MIPs (2019 and beyond), 100% of financial benchmarks for all APMs, 100 of Medicare Advantage's clinical utilization cost, > commercial payers' clinical utilization cost

III. Ensure Robust Risk and Severity Adjustment on Each and Every Patient! (continued)

D. Hierarchical Condition Categories (79 since 2004), utilized for all Medicare part A, B and MACRA), C, and alternative payment models (ACOs, PCMHs, APC, bundles) (Note: HCCs are the outpatient equivalent of inpatient MS-DRGs)

E. Accurate ICD-10 diagnoses cannot be inferred from claims data but only from clinical decision making (Sum of Risk adjusted factors (RAFs) or RAS) (Note: RAF = severity of cost, not severity of illness!)

F. Average RAS = 1.0 (Maximum > 6.850!)

III. Ensure Robust Risk and Severity Adjustment on Each and Every Patient! (final)

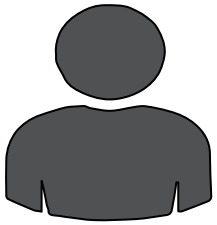
G. 200 ICD-10 RAFs (the preeminent codes) account for > 95% of risk adjustment capture in primary care (> 88% in specialty care) **(Note: Stop Utilizing 'Unspecified Codes!')**

H. Physicians are required to have 1 or 2 face-to-face encounters/annually to be eligible for risk and severity adjustment by others

I. Verify that your EHR can submit at least 12 diagnosis codes per clinical encounter!

J. Everyone in every practice needs to be aware of this methodology!

James Doe Information



Name: James Doe
Gender: Male
Age: 66 years old

Height: 64 inches
Weight: 240 pounds
BMI: 42

Chief Complaint & HPI:
Presented with right upper quadrant pain and nausea, Pertinent physical findings: BP = 145/95, P = 96 & irregularly irregular, a moderate tremor, morbid obesity and RUQ tenderness to palpation.

Past Medical History:
(1) Chronic atrial fibrillation for over 3 years, (2) High Blood Pressure, poorly controlled for 15 years, (3) Hyperlipidemia, severe for over 20 years, (4) Alcohol dependency for over 20 years, in remission for 5 years, (5) Parkinson's disease for over 5 years

Exam:
- An abdominal sonogram showing cholelithiasis, chronic cholecystitis w/o obstruction, and moderate atherosclerosis & mild ectasia of abdominal aorta,
- CBC with elevated WBC of 11,700 with a left shift and a platelet count of 118,000, and ECG showed atrial fibrillation with ventricular rate = 88/minute

Treatment:

He underwent laparoscopic cholecystectomy without complication

James Doe's Risk Adjustment Opportunities

Financial impact of knowing what to document and code!

MODERATE SPECIFICITY Documentation & Coding			
Condition	**I-10**	**HCC**	**RAF weight**
66 year old male	-	Demo.	0.288
Lap Cholecystectomy (CPT-47563)	K80.10		0.000
BMI=42	Not Coded		
Atrial Fibrillation, chronic	I48.2	96	0.295
High Blood Pressure	I10		0.000
Hyperlipidemia	E78.5		0.000
Alcohol Dep, in remission	Not Coded		
Parkinson's Disease	Not Coded		
Athero/Ectasia of Aorta	Not Coded		
Thrombocytopenia	Not Coded		
No Disease interaction			0.000
Patient RAF Score			**0.583**
PMPM Payment			**$410**
Annual Payment			**$4,918**

HIGH SPECIFICITY Documentation & Coding			
Condition	**I-10**	**HCC**	**RAF weight**
66 year old male	-	Demo.	0.288
**Lap Cholecystectomy (CPT-47563)	K80.10	N/A	0.000
BMI=42	Z68.41	22	0.365
Atrial Fibrillation, chronic	I48.2	96	0.295
High Blood Pressure	I10	N/A	0.000
Hyperlipidemia	E78.5	N/A	0.000
Alcohol Dep, in remission	F10.21	55	0.420
Parkinson's Disease	G20	78	0.708
Athero/Ectasia of Aorta	I70.0	108	0.299
Thrombocytopenia	D69.6	48	0.252
No Disease interaction			0.000
Patient RAF Score			**2.627**
*PMPM Payment			**$1,839**
Annual Payment			**$22,065**

*Includes Medicare, Parts B or C, and Excludes Part A & most D
**Inpatient

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Successful Application: Ochsner Health System's O Bar (Modeled after Apple's Genius Bar):

A retail health technology experience which has doubled compliance, improved outcomes and reduced costs:

- Technology Specialists (navigators)
- Help patients choose health/wellness applications most consistent with their healthcare plan
- Synch applications with the patient's EHR to feed information in real time
- Physicians/practitioners refer to set up wireless monitors for: glucose, BP, oxygen saturation, fitness, nutrition, nutrition, weight, lipids, fetal heart rate etc.
- Decision alerts stimulate early home based or ambulatory interventions

Successful Application: MultiCare Health System's "First Touch" Program

Primary strategy is to increase market share (goal: 1.3 million new lives within two years) by making market entry easy and convenient. First touch options include:

- Retail clinics (RediClinics)
- Urgent care centers
- Ambulatory destination centers (multidisciplinary clinics)
- Free standing EDs
- Virtual health platforms (e.g., Doctor on Demand for minor acute problems)

Successful Application: Henry Ford Health System's "Radical Convenience" Primary Care Program

- 24/7 RN Call Center for Medical Advice with 'cold and flu hotline'
- Epic My Chart provides 24/7 communication to primary care providers with Clockwise MD tool to make same day appointments; Health Alliance Plan provides no out-of-pocket costs for e-health and in network visits
- Guaranteed same day visits if scheduled by noon with early/late and weekend appointments
- Seamless referral to 17 affiliated CVS Minute Clinics for overflow and its own QuickCare Clinic downtown which is targeted to millenials

Successful Application in Rural Area: Illinois Valley Community Hospital, Peru, IL Retail Clinic (pop < 10K)

- Local primary care shortages
- Partnered with Bellin Health (retail clinic expertise) to set up a FastCare Clinic in a local Walmart with joint marketing
- Staffed by APNs who treat minor conditions and refer back to local PCPs/APNs/PAs with communication through hospital's EHR
- > 5,000 visits annually

Successful Application in Urban Area: MedStar's Collaboration with CVS Minute Clinics' Population Health Program

- Integrated electronic health care records, pharmacy benefits management program
- Preventive and primary care services at retail clinics (more convenient than MedStar's traditional venues downtown) with physician-based algorithms and protocols
- Predictive analytics utilized to address higher risk populations with targeted referrals
- E-health and telehealth visits with wireless home-based monitoring

A "Sign of the Times…" (circa 2015)

"You can't list your iPhone as your primary-care physician."

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E-Health: Most Common Uses

- Urgent care (e.g., URI, UTI, rash, flu, etc.)
- Chronic medical management
- On demand inpatient consults (e.g., rural areas)
- Emergency department case flow (MSE)
- Home healthcare services
- Post discharge/surgical care
- Behavioral health
- Contribute physicians to national pool

University of New Mexico ECHO Program:

Tele-consultations are available to rural hospitals for:

- Emergency Rooms
- Neurology
- Pediatric emergency medicine
- Pediatric heart care
- Telepsychiatry – assessments, medications management and behavioral health counseling
- Dermatology
- Obstetrics - including genetic counseling

Successful Application: Baylor Scott & White Quality Alliance (BSWQA)(2011)

- Not for profit subsidiary of BSW Health System
- One of the largest ACOs in the country with 4,700 physicians, 46 hospitals, hundreds of ambulatory healthcare clinics and organizations serving over 500,000 patients
- 'Entry point redesign' through development of a "Member Solution Center" to optimize appropriate entry point for each patient based upon insurance benefit design and clinical profile, ideally with a benefit plan contracting directly with BSWQA with incentives to remain 'in network'

Successful Application: Baylor Scott & White Quality Alliance (BSWQA)(2011) (cont.)

- Many new patients assigned a patient-centered medical home as their 'entry point' with initial and annual proactive wellness and biometric assessment
- Identification of risks, closure of preventive care gaps, and initiates a therapeutic personal doctor-patient relationship with a comprehensive care plan
- Feeds into predictive analytics and segmentation into beneficiary sub-populations
- Complex patients' care are led by "comprehensivists"

Ambulatory Surgery Centers: A Growing Trend: > 5,500 ASCs and > 23 million surgeries annually (30% Medicare)

- Routine surgeries (> 3,000) performed at a lower cost structure (particularly in light of declining reimbursement)
- Vast majority of surgeries are 'same-day' and don't require hospital infrastructure or support
- Ambulatory surgical volumes have tripled in past 10 years whereas inpatient volumes are flat (nationwide) or have declined
- Opportunity to collaborate with physicians (90% of ALL ASCs have some physician ownership with a growing number of hospitals assuming majority interest)

Again…Consumer Emphasis!

- ✓ Lower cost and lower infection rate
- ✓ Greater scheduling flexibility (not Dr. B's block scheduling opening)
- ✓ Consumer friendly payment plans (for deductible and co-payments)
- ✓ Focus on patient/family comfort and amenities (valet parking, online registration, pre-authorization, immediate responsiveness, personalized attention)
- ✓ Close communication with primary care physician/APN/PA/care coordinator
- ✓ Robust pre-operative risk assessment

What *are* the First Touchpoints?

1. Scheduled clinic visits (80%-growing at 3% annually)
2. Urgent care (13%-growing at 8% annually)
3. Emergency department (5%-declining annually)
4. Retail clinics (2%-growing at 15% annually)
5. E-health (1%-growing at triple digit rates)

What do you think this list will look like in 5 years? According to Wall Street investors the new order will be: 5, 4, 2, 3, 1

Best Estimate within 10 Years (WSJ):

- 5%-10% of all services inpatient
- 10%-20% of all services ambulatory
- 80% of all services virtual (some organizations are 35%-40% today)

Strategic imperative: move inpatient services to ambulatory services and ambulatory services to virtual services.

A sobering thought...

"If you don't like change, you are going to like irrelevance even less."

- General Eric Shinseki, Former Chief of Staff, US Army and Secretary of Veteran Affairs, VA Hospital System

Post-Polling Questions

I am ____ in my understanding of how payors and health plans define quality in an ambulatory setting.

I am ____ in my understanding of how commercial payors incentivize hospitals based on care measures.

I am ____ that I will apply the knowledge gained from this educational training to assume risk and participate (or continue to participate) in value-based payment models to prepare for population health.

Questions, Discussion, and Next Steps…

DRCHSD Program – Upcoming VBC Webinars

May 27

Successful Models to Engage Providers in Value-Based Care, Eric Shell, Stroudwater Associates

June 3

Best Practices to Work With Community Partners on Population Health Initiatives, Toniann Richard, Health Care Collaborative of Rural Missouri

https://www.ruralcenter.org/drchsd/events

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