Patient Quality Alliance

Clinic Onboarding

PQA
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Education Sections

CIN & Value-Based Care: What is PQA? (10 Slides)

Performance Scorecard (3 Slides)

Role of Team Members (3 Slides)

Patient Attribution (5 Slides)

Box Report: KPI (17 Slides)

Attribution	AVW/AWWE	XCM	HCC

Box Report: Quality (5 Slides)

Utilization (8 Slides)

Advance Care Planning(ACP) (3 Slides)

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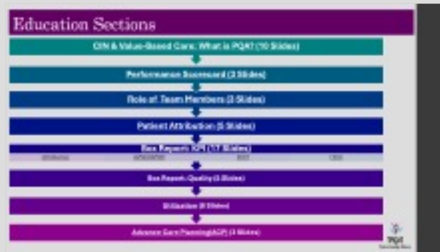
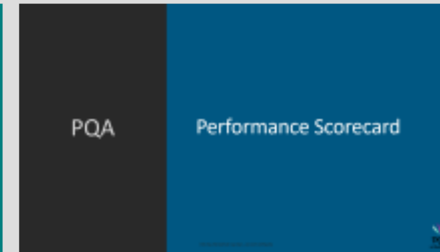
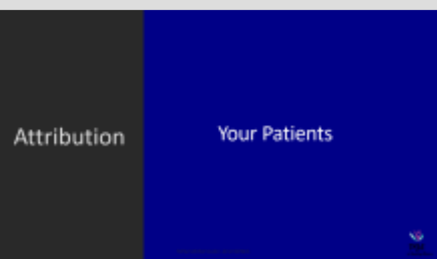
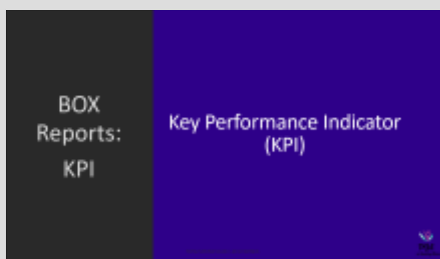
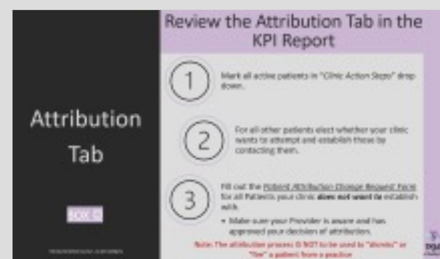
PQA Clinic Onboarding

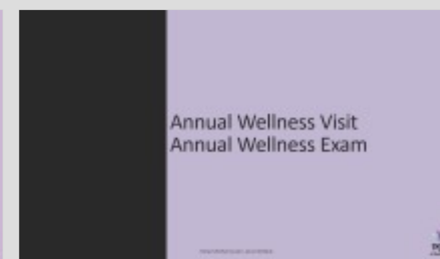


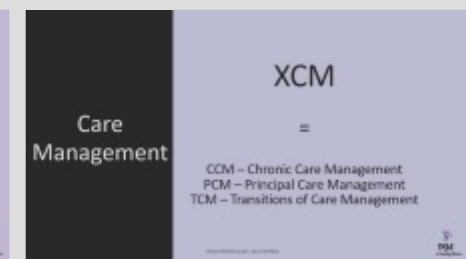


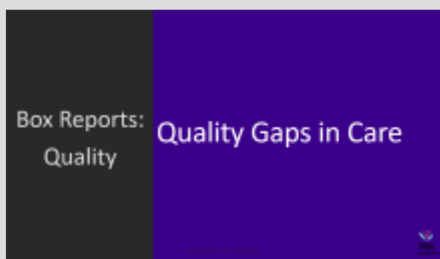


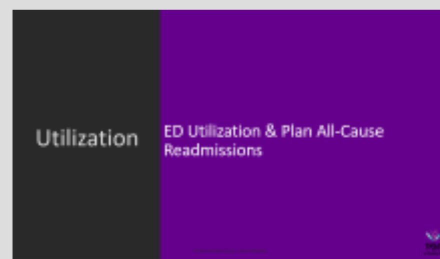


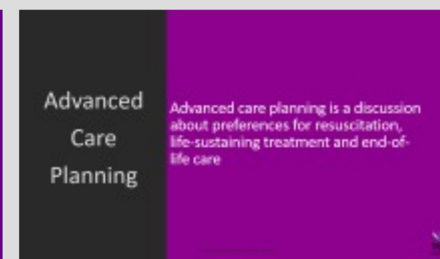












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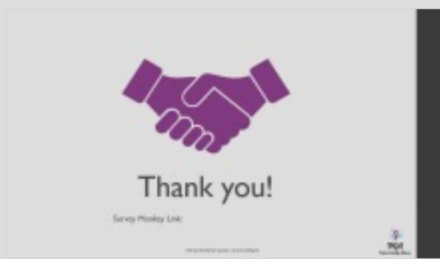

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CIN & Value-Based Care

What is PQA?

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PQA is a Clinically Integrated Network (CIN)

Key things to know about a CIN:

- They bring patients, providers, and payers together
- Through population health strategies, they help providers provide value-based care
- Value-based initiatives help move providers from fee-for-service to value-based care

PQA-Specific CIN:

- The PQA team is an extension of your team to support your clinic in meeting value-based care metrics with contracted payers (get credit for the great care you provide)
- PQA is NOT a payer, but a liaison to help champion provider and patient needs
- The PQA CIN is eligible to earn rewards for providing excellent value-based care
- A team member to help develop best-practice process for ALL patients, not just “PQA” patients
- Assist providers, care managers, and clinical support staff in ensuring patients needs are being met

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PQA Mission Statement

Patient Quality Alliance is a healthcare team dedicated to increasing the quality and decreasing the cost of healthcare for everyone.

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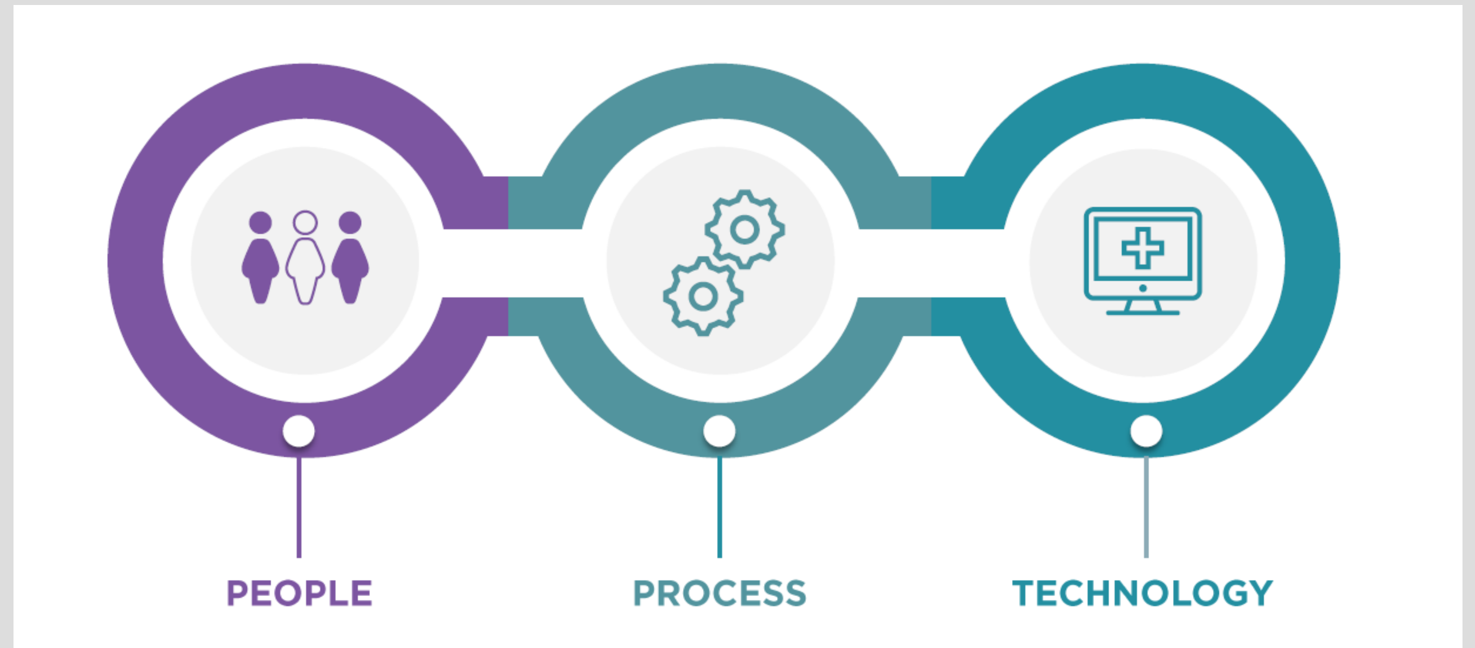
PQA Philosophy



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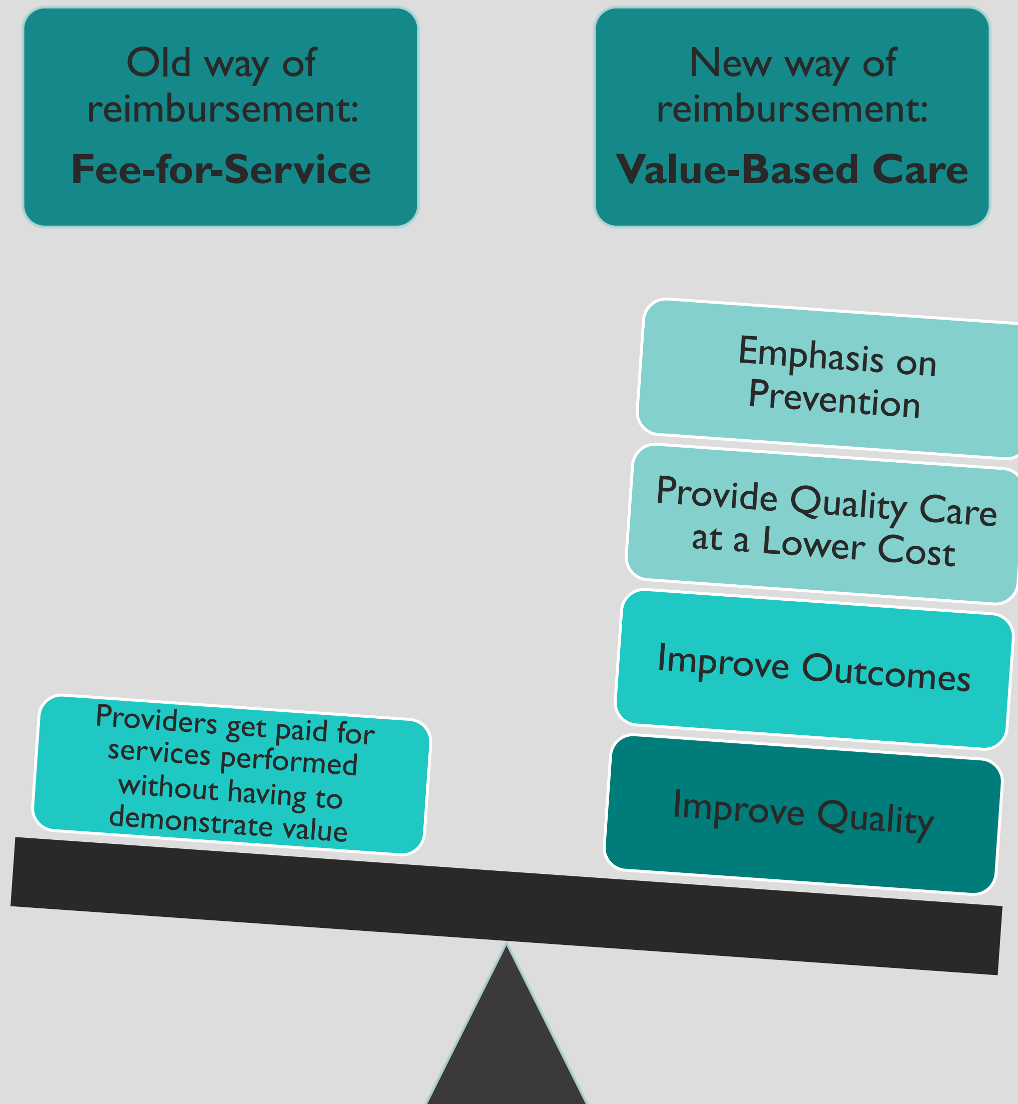
CIN is Value – Based Care



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Patient Benefits

Prevention-focused and comprehensive care

- Team-based care approach focused on prevention

Preventative Care

- Annual Wellness Visits
- Personal Care Plan
  - Better quality of life

Care Coordination

- Access to a Network of Quality Providers

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Provider Benefits

Team Approach

- Opportunity to collaborate in a network of PCPs and Specialists

Resources

- Provider tools and workflows for best practices available.
- Education and support in meeting value-based care initiatives

Quality Improvement Initiatives

- Support to identify opportunities for improvement.
  - Clinic flow
  - Care opportunities
  - Documentation and coding
  - Guidance interpreting value-based arrangements and regulations

Financial

- Opportunity for shared savings.
- Access to up-to-date billing and coding regulations

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Fundamentals of Value – Based Care

After mastering the fundamentals of value-based care, we feel you will be able to answer these questions for every patient in your clinic:

- Do you know who your patients are?
- Are you aware of each time they have had an inpatient event?
- Are you aware of each time they have had an emergency department event?
- Does your patient participate in annual wellness and preventative care visits with their PCP?
- Are you aware of their chronic conditions and if they are managed or uncontrolled?
- Are you aware of the preventative screenings they qualify for, have received, or still need?
- Are you getting credit for the non-face-to-face time with your patients with chronic conditions?
- Are you aware of the advance care plans of your patients?

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PQA Payer Arrangements

Medicare (ACO)

- Medicare Shared Savings Program (MSSP)

Medicaid (VCO)

- Health Connections Value Care Program (HCVC)

Blue Cross of Idaho

- PQA ConnectedCare (QHP)
- Value-Based (PPO)
- True Blue (MA)

PacificSource

- PQA Navigator (QHP)
- Medicare Advantage (MA)

Moda Health

- PQA Select (QHP)

UMR(Healthscope) – PMC Employees

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PQA Team

- Executive Director
  - Brock Merrill
- Medical Director
  - Dr.Vermon Esplin
- Operations Director
  - Brad Rogers
- Care Managers
  - Ashley Smith, RN
  - Randee Hokanson, RN
  - Katelyn Chandler RN
- Documentation and Coding Specialist
  - Jennifer Bell, CPC, CRC
- Credentialing Specialist
  - PQA

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Performance Scorecard

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Performance Scorecard

2024 CIN Performance Scorecard

YOUR CLINIC NAME

All Providers

High Performer	Mid - Performer	Low Performer	Non-Performer	Clinic Score
21-30 Points	15-20 Points	9-14 Points	0-8 POINTS	
100% of Allocated Funds	75% of Allocated Funds	50% of Allocated funds	0% of Allocated funds	

Metric	2 Points	1 Point	0 Points	Score
Engagement				
Care Management Rounding*	≥ 9 per year	5 - 8 per year	≤ 4 per year	
Educational Sessions Attended*	> 50%	50%	< 50%	
PQA Committee/Council/Task Force Participation*	≥ 1	N/A	0	
Provider Meeting with PQA Medical Director*	≥ 1	N/A	0	
Key Performance Indicators:				
Patient Attribution Status*	82.5%	80.0%	77.5%	
Annual Wellness Visits (Medicare)**	67.5%	65.0%	62.5%	
Annual Wellness Exams (Non-Medicare)**	67.5%	65.0%	62.5%	
Chronic Care Management, Principle Care Management, Transitional Care Management (xCM)**	14.5%	12.0%	9.5%	
Hierarchical Condition Category (HCC) Recapture Rate*	82.5%	80.0%	77.5%	
Members Without Office Visits**	27.5%	30.0%	32.5%	
Quality				
Breast Cancer Screening*	63.0%	60.5%	58.0%	
Colorectal Cancer Screening*	67.4%	64.9%	62.4%	
Hemoglobin A1c Control for Patients with Diabetes*	94.5%	92.0%	89.5%	
Controlling High Blood Pressure*	75.5%	73.0%	70.5%	
Medication Adherence (Cholesterol, DM, HTN)*	93.5%	91.0%	88.5%	
Depression Screening and Follow Up*	78.5%	76.0%	73.5%	
Utilization				
Plan All-Cause Readmissions*	0.4896	0.5146	0.5396	No Data

Eligible Shared Savings Formula Components:

Primary Care (60%)
- Practice Site Engagement
- Practice Site KPIs
- Practice Site Quality Performance
- Practice Site Utilization

Specialists (40%)
- Practice Site Engagement
- Network & Specialty KPIs
- Network Quality Performance
- Network Utilization

10/24/2023 * measured year-to-date ** measured on rolling 12 months ***network value

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What is Shared Savings?

Payment strategy offering incentives for providers to:

Reduce health care spending for a defined patient population

- *Then*

Offer (or reward) a percentage of the net savings as a result of your efforts.

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Team Based Approach

Role of Team Members

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What is Your Role?

Practice Manager

- Oversee the success of implementing Value base care and initiatives into you daily workflow.
- Staff education, collaboration, ongoing monitoring, and evaluation of internal processes

Documentation & Coding/Billing

- Work with your providers to capture the most complete and highest specificity of diagnoses for every patient

Clinical Support and Care Management

- Be a part of the team-based approach towards value-based care in carrying out services for annual wellness, chronic condition management, and transitions of care management
- Communicate with the patient and care team to provide coordination of care.

Reception

- As Part of the team-based care, ensure patients are scheduled for their next service or appointment before they ever leave the clinic.
- Ensure your patients are scheduled for follow up visits after a hospital or emergency department encounter.
- Develop and foster strong relationships with your care team to be a support and help as needed.

Provider

- Get credit for the great care you provide by documenting diagnoses to the highest specificity and by utilizing input from the coding and billing team
- Support all fellow providers in your practice to meet value-based standards of care
- Create a strong communication process with your team to provide the care each patient needs to meet the value-based care initiatives in your practice.
- Consider programs such as chronic condition management and transitions of care management to get credit for the non-face-to-face work you are already doing

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Your Clinics Next Steps:

<u>Your PQA Champions:</u>

- Practice Manager Champion:
- Care Manager Champion:
- Documentation & Coding Champion:
- Provider Champion:

Establish/Attend monthly Care Management Rounding's:

____

<u>Get access to PQA resources</u>

- Box
  - Tools and Resources
  - Leadership
    - Financials and scorecard
  - Care Management
    - KPI Report
    - Quality Report
- Lightbeam
- Care Link

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Attribution

Your Patients

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Patient Attribution

Attribution is the way payers(insurance company) deem a provider responsible for a patient's care.

Attribution most often will fall to a PCP .

The PCP is expected to manage the overall health care related needs of the patient assigned(attributed) to them. Including, referrals to specialties, etc.

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How Does Attribution Get Assigned?

How do payers attribute patients to providers?

They may use a combination of the following:

Payer Member Roster

- Patient said either "This is my PCP." or "I want this person to be my PCP."

Demographics from an EMR/EHR

- If a large system EMR such as Athena or EPIC has a PCP field, sometimes this will drive attribution

Claims

- Plurality of visits (billed claims for visits)
  - This is often how a Specialty Provider becomes the attributed or "responsible" provider for all care

Patient Attribution Change Request Form

- In some cases, there is a process to have a payer manually change the attributed provider for Lightbeam reports only.

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Patient Attribution Change Request Form

Patient Attribution
Change Request Form

Patient Name:______________________ **Date of Birth:**__________

Managed Care Contract:__________ Attributed Provider:______________

Does the attributed provider provide services at another organization: ☐ Yes ☐ No

Name of the other Organization: ______________________________

Patient deceased: ☐ Yes ☐ No Date of Death:__________

Patient dismissed ☐ Yes ☐ No Date of dismissed:__________

Does Patient live in an SNF or ALF: ☐ No ☐ Yes (if yes tell us the name of facility)

Name of Facility:______________________________

Primary Care Provider is actually seeing: ______________________

Source of this information: ☐ Patient Reported ☐ Record Request received ☐ Other:__________

Have attempted to Establish Care: ☐ Yes ☐ No

Result of attempt: ______________________________

Do not want to establish care with this patient: ☐ Yes ☐ No

Additional Information: ______________________________

____

Form Completed by: ______________ Clinic:__________

Job Role:______________ Date:__________

Complete this digital form and upload to Box for processing. Updated: 05/10/2024 JB

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Patient Attribution – Why does it matter?

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BOX Reports: KPI

Key Performance Indicator (KPI)

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Review the Attribution Tab in the KPI Report

Attribution Tab

BOX ☺

1. Mark all active patients in "*Clinic Action Steps*" drop down.

2. For all other patients elect whether your clinic wants to attempt and establish those by contacting them.

3. Fill out the *Patient Attribution Change Request Form* for all Patients your clinic ***does not want to*** establish with.
   - Make sure your Provider is aware and has approved your decision of attribution.

Note: The attribution process IS NOT to be used to "dismiss" or "fire" a patient from a practice

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Clinic Attribution Thought Process

Clinic Attribution Thought Process

PACRF = Patient Attribution Change Request Form

Occasionally clinics will receive reports with patients they do not consider to be one of their patients but, the payer(insurance) does. Please use the process outlined below to help PQA reconcile these concerns and ensure continued of care for the patient.

Is this patient an active patient in your clinic?	
YES Mark "Patient Active" in the Attribution Report in Box	**NO** Go to the next question
NEXT	
Is the patient deceased or been dismissed from the clinic?	
YES Send PACRF to PQA for Processing, mark "Patient Attribution Submitted" in Attribution Report in Box.	**NO** Go to the next question
NEXT	
Do you know who the patient is actually seeing as a PCP?	
YES Send PACRF to PQA for Processing, mark "Patient Attribution Submitted" in Attribution report in Box.	**NO** Go to the next question
NEXT	
Do you want to Establish Care with this patient?	
YES Begin to Contact patient to Establish care – Mark "Contacting to Establishing Care" in the Attribution Report In Box	**NO** Send PACRF to PQA for Processing, mark "Patient Attribution Submitted" in Attribution Report in Box.
Remember	
If a patient is attributed to one of your providers and has never been seen in your practice it is because the patient has chosen one of your providers as their Primary care Provider when signing up for insurance. This is an opportunity for your clinic to gain a new patient. PQA recommends contacting the patient for formally establish care.	

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Annual Wellness Visit
Annual Wellness Exam

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Wellness – Why is it so important?

- Creates a *Proactive* Game Plan
- Focus on Preventative Care & Screenings
- Quality Measures
- Recapture Chronic Condition Diagnoses (HCC Recapture)
- Helps build provider – patient relationship

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WHAT ARE ANNUAL WELLNESS VISITS / EXAMS?

Annual Wellness Visit (AWV)

- Medicare & Medicare Advantage
  - Initial Preventative Physical Exam (IPPE)
  - Initial Annual Wellness Visit (IAWV)
  - Subsequent AWV

Annual Wellness Exam (AWE)

- Commercial/Medicaid Plans
  - Well Child/Adolescent Visits
  - Adult Wellness

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Initial Preventative Physical Exam

"**Welcome to Medicare**" – Preventive Visit

- No later than the first 12 months after the patient's Medicare Part B eligibility date
- Medicare pays for **1** IPPE per lifetime

Initial Annual Wellness Visit

- 365 +1 after last AWV or IPPE
- Once in a lifetime benefit

Subsequent Annual Wellness Visit

- 365 +1 after last AWV

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What is included in Annual Wellness Visits/Exam/IPPE.

Annual Wellness Exam

Well Child Visit (1-11)
Well Adolescent Visit (12-17)
Annual Wellness Exam Adult (18+)

Included but not limited to

- Vital signs (appropriate for age)
- Patient Medical and family and social history.
- Health Risk Assessment
- Develop and/or update current list of providers and medications
- Assess depression, anxiety, stress, dementia, memory loss
- Discuss your risk factors and what lifestyle modifications or treatment options can help.
- A screening schedule for appropriate preventive services as needed.
- Physical exam maybe included, with a ROS of systems, (age appropriate)

All AWVs

- Establish or update the patient's current medical and family history including allergies, past surgeries, hospital stays, and treatments
- Perform a medication reconciliation, including all prescribed medications, vitamins, and supplements
- Review any history or present use of opioids; If the patient is using opioids, review the benefits of alternative pain therapies, even if the patient does not have opioid use disorder but may be at risk
- List the patient's current medical providers and suppliers
- Record measurements of height, weight, body mass index (BMI), blood pressure, and other routine measurements
- Screen for depression
- Screen for balance, gait, and fall risk
- Record history of alcohol, tobacco, or illicit drug use, and screen for alcohol misuse
- At the patient's discretion, Advance Care Planning may be furnished
- Screen for Substance Use Disorder
- Discuss history and present use of opioids

IPPE Requirements	Initial and Subsequent AWV Requirements
• Visual acuity screen • Review diet and physical activities • Includes a brief written plan, such as a checklist, for the beneficiary to obtain a once-in-a-lifetime screening electrocardiogram (EKG/ECG), and other preventive services Medicare covers including the Annual Wellness Visit	• Complete or update the Health Risk Assessment (HRA) • Screen for cognitive impairment • Establishing or updating a screening schedule for the next 5 to 10 years, including screenings appropriate for the general population and any additional screenings that may be appropriate because of the individual • Create a ***Personalized Prevention Plan*** unique to the patient, and provide appropriate referrals to health education or preventative services

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KPI Report

BOX REVIEW ☺

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Care Management

XCM

=

CCM – Chronic Care Management
PCM – Principal Care Management
TCM – Transitions of Care Management

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XCM

Chronic Care Management (CCM)

- Billable Care Management Services for care provided outside of the normal office visit
- For patients with 2 or more chronic conditions that you are managing
- Must document 20 minutes per month of CCM time

Principle Care Management (PCM)

- Billable Care Management Services for care provided outside of the normal office visit
- For patients with at least one chronic condition that you are managing
- Must document 30 minutes per month of PCM time

Transitional Care Management (TCM)

- Billable Care Management Services for care provided to patients after a Transition of Care from hospitalization back to a community/home setting
- For patients who recently discharged from an inpatient hospitalization setting
- Call patient within 2 business days of discharge.
- Must have face-to-face within 7 or 14 days depending on complexity.

What is CCM & Why Does it Matter?

"The Centers for Medicare & Medicaid Services (CMS) recognizes Chronic Care Management (CCM) as a critical component of primary care that contributes to better health and care for individuals."

- Helps keep patients healthy between office visits
- Helps manage long-term health problems
- Provides patients access to additional services
- Affects reimbursement

BOX REVIEW ☺

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Hierarchical Condition Categories

HCC

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Hierarchical Condition Category (HCC) Model

A system developed by Medicare and private payers to estimate future health care costs for a group of beneficiaries or subscribers

Now, used to normalize cost, quality and outcome and quantify disease burden

Communicates acuity of patient

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What are HCC's?

Hierarchical Condition Category (HCC) is a term that describes the grouping of similar diagnoses into one related category (an HCC) to be used in a risk adjustment payment model. Risk adjustment payment models are regulated by the federal government to reimburse participating health insurance plans for the medical care of enrollees.

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How a RAF is Calculated. . .

RAF
(Risk Adjustment Factor)

=

Disease Complexity
(Diagnosis codes via Claims)
US

Demographics
- Age/gender
- Living situation
- -Dual covered
- -Geography location

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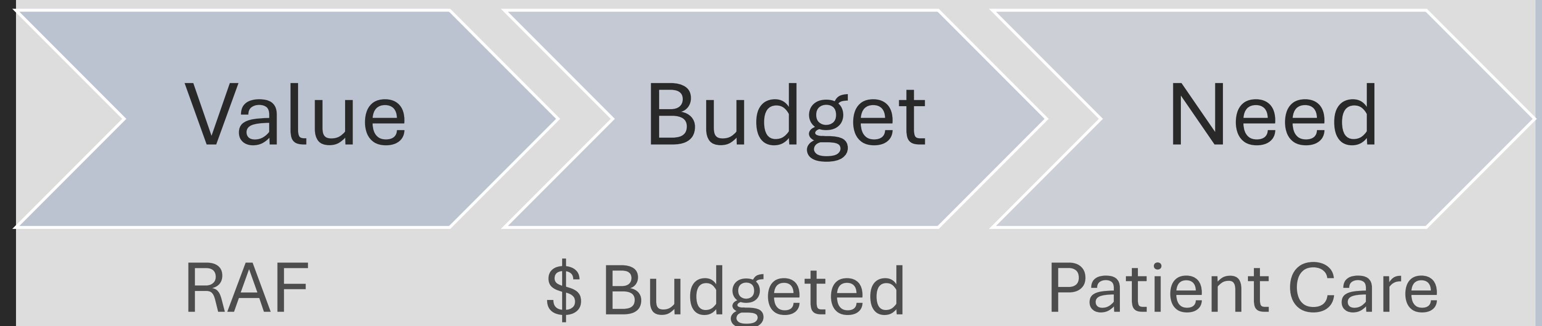
Hierarchical Condition Categories



BOX REVIEW ☺

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Box Reports: Quality

Quality Gaps in Care

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What are Gaps in Care?

A “**gap in care**” or “**open gap**” is when, as far as a payer knows, a quality measure has not been met.

- Example: Your diabetic patient has not had his A1c.

A “**closed gap**” is when the provider/clinic has submitted documentation to the payer proving the quality measure has been met

- Example: A mammography screening (breast cancer screening) has been completed for a 65-year-old female patient and PCP has documentation on file.

As a CIN, PQA helps you to identify these “gaps in care” and get the documentation to the payer. The goal is to be proactive/create a process to do this throughout the year rather than scramble to submit this “proof” at the end of the year.

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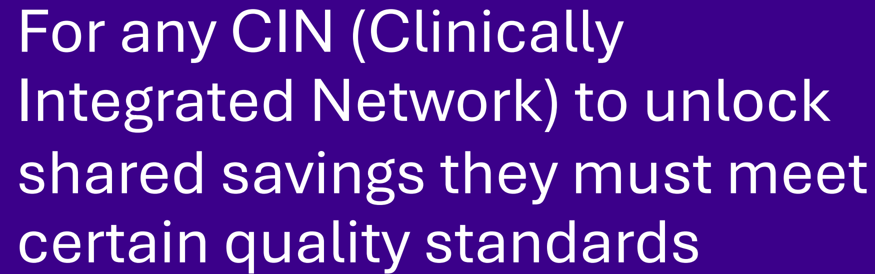
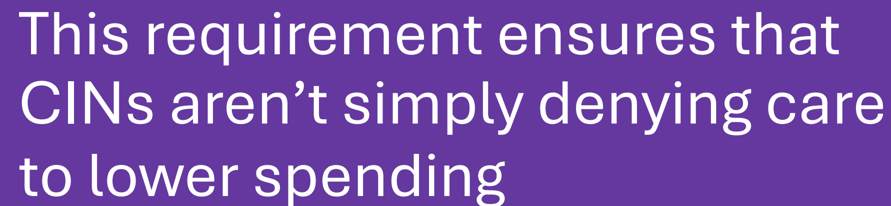
Why are Quality Measures so Important?





If quality standards aren’t met, shared savings is denied or reduced regardless of how much costs were lowered

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PQA Gaps In Care

Cancer Screenings

- Breast
- Cervical
- Colorectal

Medication Management

- Medication Adherence
- Medication Reconciliation Post-Discharge
- Statin Therapy

Preventative Care and Screening

- Falls
- Influenza Immunization
- Tobacco Use and Cessation
- Depression Screening

Chronic Conditions

- Comprehensive Diabetes Care
- Controlling High Blood Pressure
- Depression Remission at Twelve Months

Care of Older Adults

- Functional Status Assessment
- Medication Review
- Pain Assessment

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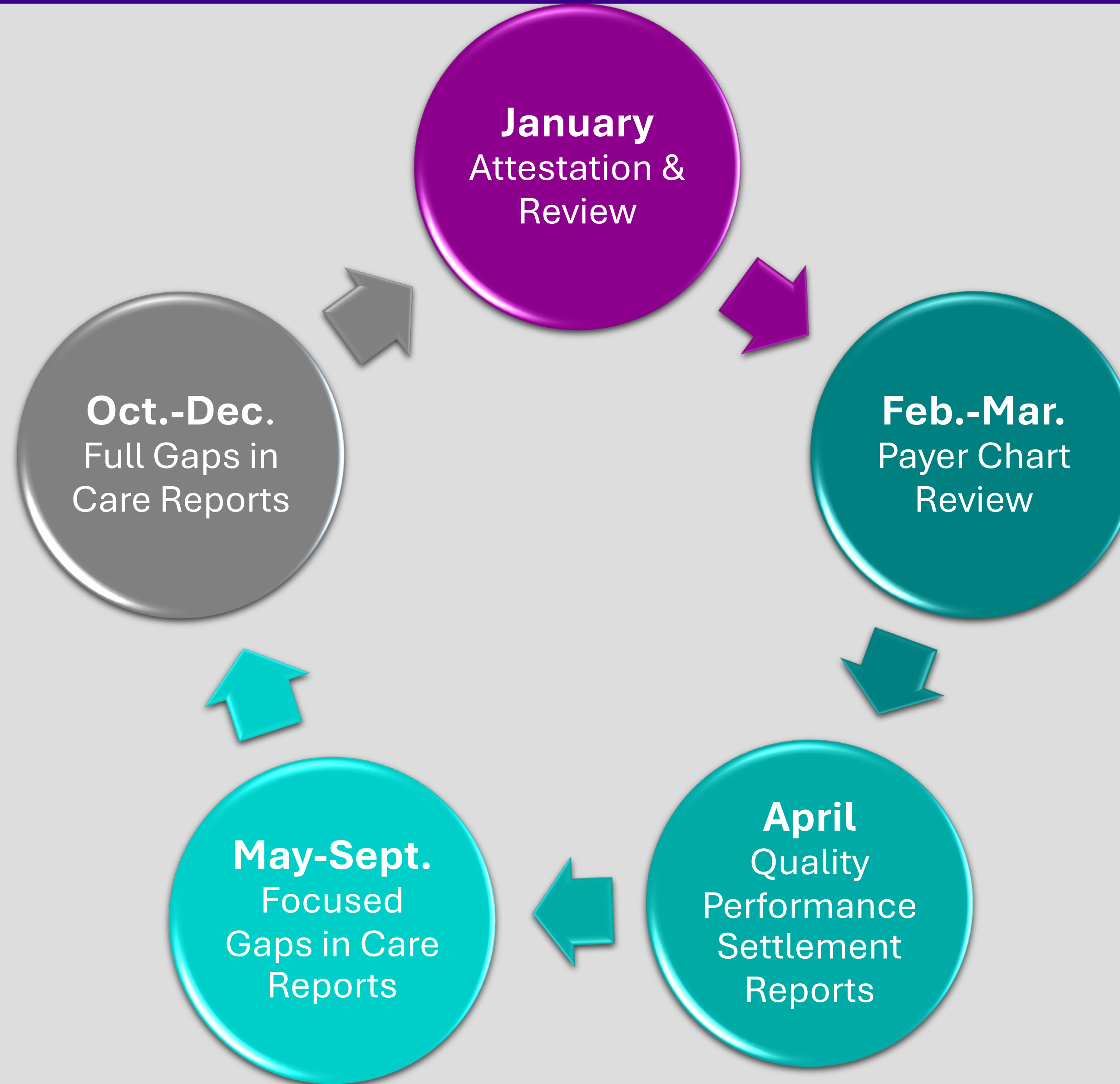
PQA Gaps In Care



BOX REVIEW ☺

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Utilization

ED Utilization & Plan All-Cause Readmissions

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ED Utilization

Assesses emergency department utilization among health plan members

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ED Utilization - Measure

- The ratio of observed ED visits to expected ED visits (O/E)
  - This includes a methodology developed by the NCQA and based on member health status and demographic factors (risk adjusted to remove differences in health and other risk factors that impact measured outcomes but are not under the practitioner's control)

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ED Utilization – Terms

Avoidable ED Visits

- ED visits which are for non-urgent or primary care treatable issues

Observed ED Visits

- Total # of observed ED visits

Observed ED Visits/1,000 members

- Total # of observed ED visits ÷ # of members in the eligible population, x 1,000

of Expected ED Visits

- The total # of expected ED visits

Expected ED Visits/1,000 members

- Total # of expected ED visits ÷ # of members in the eligible population, x 1,000

Total Variance

- Total variance from risk adjusted weighting and calculation of expected events

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ED Utilization – Reducing Avoidable ED Visits

- Create a strategy: *Call Your PCP Before Heading To The ED*
- Develop handouts that direct people to the right place for care
- Provide condition specific follow up guidance to patients
- Promote the use of personal health triage applications (app to help pts determine if an ED visit is the best choice)
- Target your ER super-utilizers for one-on-one education
- Offer telehealth as a possible alternative to the ER

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Plan All-Cause Readmissions

Assesses the rate of adult acute inpatient and observation stays that were followed by an unplanned acute readmission for any diagnosis within 30 days after discharge

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All-Cause Readmissions - Measure

A risk-standardized readmission rate for pts **≥65 yo** hospitalized at a short-stay acute care hospital and experienced an unplanned **readmission for any cause** to an acute care hospital **within 30 days of discharge.**

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All-Cause Readmissions

- A high rate of patient readmissions may indicate inadequate quality of care in the hospital and/or lack of appropriate post-discharge planning and coordination.
  - Unplanned readmission are associated with increased mortality and higher health care costs.
- Unplanned readmissions can be prevented by standardizing and improving coordination of care after discharge and increase support for patient self management

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Advanced Care Planning

Advanced care planning is a discussion about preferences for resuscitation, life-sustaining treatment and end-of-life care

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Advanced Care Planning

Evidence of Advance Care Planning must include ONE of the following:

The presence of an Advanced Care Plan in the medical Record

- Living Will
- Power of Attorney
- Health Care Proxy
- POLST (Form)
- 5 Wishes

Documentation of an ACP discussion with the provider and date of discussion

- Once in the measurement year
- Oral statement of conversations with relatives or friends about:
  - End-of-life care
  - Patient designation of individual who can make decisions on their behalf
  - Notation that ACP has already been executed

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Advanced Care Planning – What Closes the GAP

Note: If you spend 16-30 minutes of face-to-face time with the patient, family member(s), and/or surrogate you may be eligible for additional reimbursement (Code 99497)

Form on File	Documentation Complete & Gap Closed
***No* Form on File**	Patient given information and will schedule follow up to finalize Documentation Complete & Gap Closed
***No* Form on File**	Discussion about ACP between provider and patient/caregiver documented in chart Documentation Complete & Gap Closed
***No* Form on File**	Patient declines to complete form and declines discussion about ACP Documentation Complete & Gap Closed
Advance Care Planning <u>NOT</u> Discussed	**Gap not closed**

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Thank you!

Survey Monkey Link:

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