ACO Announcements

• Reminders:
  – ACO Notifications
  – PECOS-Maintain active enrollment
  – 2017 Patient Prospective Lists
  – Upcoming provider meetings:
    • Clinical Integration Strategies In Primary Care: Internal Medicine & Family Practice Physicians and Office Managers.
      Tuesday, May 23, 2017
      Catholic Health Administrative Regional Training Center
      Registration/Dinner 5:00 - 5:30 p.m/Meeting 5:30 – 7:00 p.m.
    • Operations Roundtable QI workshop: Internal Medicine and Family Practice Offices.
      Wednesday, June 14, 2017 from 7:30-9:00 a.m
      Millennium Buffalo Hotel, McKinley Room
    • Advanced Care Information meetings- Coming soon
Agenda

• Understand Patient Attribution Methodology and connecting patients with PCP
• Strengthening Referral Agreements
• Medical Neighborhood/Impact of coordinated care
• Q&A section
“Population Medicine”

– Design, deliver, coordinate high quality health care services for a defined population

Population Health Management

+ Population Medicine

= Accountable Care
The Accountable Care Organization Cornerstone

Coined by Dr. Don Berwick, former administrator of CMS and head of Institute for Healthcare Improvement
What is an Accountable Care Organization?

Made up of providers who voluntarily agree to work together to coordinate high quality care for patients

Goal:
- Increase quality of care and patient satisfaction
- Promote Better Health
- Decrease wasteful cost

How is quality measured?
- Health Plans – e.g. HEDIS measures
- Medicare Shared Savings Program - Annual submission of clinical data on sample of patients for 31 quality measures
Quality Metrics...

**Patient Experience**
- Timely appointments
- Patient rating of MD
- Access to specialists

**Care Coordination/ Patient Safety**
- All condition readmissions
- Falls Risk
- Medication Reconciliation
- Meaningful use

**Preventive Health**
- Influenza/Pneumococcal immunizations
- Depression screening
- Colon rectal/Mammography screening

**Disease Specific Measures**
- Diabetes
- Hypertension
- Ischemic Vascular Disease
Patient Attribution

• Attribution of patients is based on Primary Care Service codes (Specific E&M and HCPCS codes)
  – These codes are used by Primary and Specialty physicians

• If a patient doesn’t have a PCP or has not seen a PCP, then he/she may be assigned to a Specialist based on the majority of services received from the participating specialist.
ACO Attribution Model - taking care of a defined population

**STEP 1:**
PCP (IM, FM, GP, Geriatrics)  
Tax ID Number (TIN)  
Attribution: patients with a PCP visit in the past 12 months, updated quarterly  
Patient must have **at least one** annual visit for continuous attribution

**STEP 2:**
SCP  
Tax ID Number (TIN)  
Attribution: patients with **NO** PCP visit in the past 12 months, for whom SCP billed any of the 99201-99215 codes  
Work to connect these MCR fee for service patients to a PCP
Specialty Attribution

• These are patients going to Specialists numerous times and are not circling back to the Primary Care Provider
  – CMS use these claims to calculate our benchmark and patient attribution.
  – Quality Results difficult to produce
  – Patients without a Primary Care Provider
Referral Agreements

- Specialist Referral Agreement
- Hospitalist Referral Agreement
- Palliative Care Referral Agreement
- Behavioral Health Referral Agreement
- Midlevel Information Sheet
Medical Neighborhood

Nicole Harmon, MBA, PCMH CCE
Senior Director, HANYS Solutions
Practice Advancement Strategies
Overview

• Current landscape
• Medical neighborhood
• Patient-Centered Specialty Practice (PCSP)
• Impact of coordinated care
• Recap
Time of Change

“(Medicine) is an imperfect science, an enterprise of constantly changing knowledge, uncertain information, fallible individuals, and at the same time lives on the line.

Better is possible. It does not take genius. It takes diligence. It takes moral clarity. It takes ingenuity. And above all, it takes a willingness to try.”

-Atul Gawande
System-Wide Changes

• Moving the needle requires a shared commitment
• Average Medicare beneficiary
  – Sees 7 physicians per year
  – Fills 20+ Rx per year
  – Has an average of 2 referrals per year

## Effects of Care Fragmentation

<table>
<thead>
<tr>
<th>Description</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care providers (PCPs) reporting that they always get information back after a referral:</td>
<td>37%</td>
</tr>
<tr>
<td>PCPs routinely notified about discharges:</td>
<td>17-20%</td>
</tr>
<tr>
<td>PCP involved in discussion before discharge:</td>
<td>3-23%</td>
</tr>
<tr>
<td>Discharge summaries received by PCP within 2 weeks:</td>
<td>20-40%</td>
</tr>
<tr>
<td>Discharge summaries without info on pending tests:</td>
<td>65%</td>
</tr>
<tr>
<td>Discharge summaries without discharge medications:</td>
<td>21%</td>
</tr>
<tr>
<td>Discharge summaries without follow-up plans:</td>
<td>14%</td>
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</tbody>
</table>

Overarching Goal

- Right care
- Right time
- Right place
- Right quality
- Right cost
Medical Neighborhood
### What is Care Coordination?

<table>
<thead>
<tr>
<th>Author</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cassady 2000</td>
<td>“Coordination addressed only the actual integration of services between a primary care provider and specialty care, because consumers might not know the characteristics of the practice (structure) that facilitate coordination of care.”</td>
</tr>
</tbody>
</table>
| Chen 2000       | - “There does not seem to be a clear, universally accepted definition of coordinated care for chronic illness.”  
- “Coordinated care programs, by our definition, are those that target chronically ill persons ‘at risk’ for adverse outcomes and expensive care and that meet their needs by filling the gaps in current health care. They remedy the shortcomings in health care for chronically ill people by (1) identifying the full range of medical, functional, social, and emotional problems that increase patients’ risk of adverse health events; (2) addressing those needs through education in self-care, optimization of medical treatment, and integration of care fragmented by setting or provider, and (3) monitoring patients for progress and early signs of problems. Such programs hold the promise of raising the quality of health care, improving health outcomes, and reducing the need for costly hospitalizations and medical care.” |
| Cooley 2003     | Coordination themes: role definition, family involvement, child and family education, assessment of needs/plans of care, resource information and referrals, advocacy |
| Fletcher 1984   | - Coordinated care components: “written evidence that the other physician was aware of the primary physician’s involvement, and that 1) the primary physician arranged visit to the other physician or knew about it beforehand, or 2) the primary physician was aware of the patient’s visit to the other physician after the visit”  
- Fletcher et al. “did not consider these components acts of coordination in themselves, but rather conservative markers of the coordinating process.” |
| Flocke 1989     | “Coordination of care refers to the incorporation of information from referrals to specialists and previous health care visits into the current and future medical care of the patient.” |
| Flocke 1997     | “Coordination of care is defined as the patients’ perception of their physician’s knowledge of other visits and visits to specialists, as well as the follow-up of problems through subsequent visits or phone calls.” |
| Forrest 2000    | “Optimal coordination involves the documentation of patient care activities, interprovider communication, and the integration of service delivery into a single medical home” (citing Institute of Medicine 1996 and Starfield 1998) |
| Gilbert         | “Coordinated care is a multi-disciplinary approach that focuses on achieving patient outcomes within effective time frames which have
NCBI Working Definition

The deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services.

Organizing care involves the marshaling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care.

Source: http://www.ncbi.nlm.nih.gov/books/NBK44012/
• Awareness
• Communication
• Follow up
Why Coordinated Specialty Care?

“25-50% of referring physicians do not know whether their patients [saw] the specialist to which they were referred… and physicians routinely misestimate the number of referrals completed”

- PCP’s report sending information 70% of the time
- Specialists reporting receiving the information 35% of the time
- PCP’s report receiving a report 62% of the time
Impact of Coordinated Care

- More efficient use of services
  - Lab, imaging, ER, hospitalization
- Improved patient experience
  - Access, coordination, clinician collaboration, involvement in care
- Improved outcomes
  - CQI, evidence-based guidelines, medication management
What is Patient-Centered Specialty Practice?
Right care
Right place
Right time
Right quality
Right cost
Patient-Centered Specialty Practice (PCSP)

- Enhance coordination between primary care (PCP) and specialty care (SCP)
- Strengthen relationships between PCP and SCP
- Improve the experience of patients accessing specialty care
- Align requirements with processes demonstrated to improve quality and eliminate waste
- Encourage practices to use performance measurement and results to drive improvement
- Identify requirements appropriate for various specialty practices seeking recognition for excellent care integration within the medical home

Source: NCQA PCSP 2016 Recognition Front Matter_FINAL 03.28.2016.pdf
Eligibility

• Non-primary care specialty MD, DO, APRN, certified nurse midwives

• State certified or licensed behavioral health practitioners:
  – Doctoral or master’s level psychologist
  – Doctor or master’s level clinical social worker
  – Doctoral or master’s level marriage and family counselors*

*Licensed by state to practice independently
Scoring Considerations

• Each standard has elements and factors
• Score at least 50% on must pass elements
• How many and how well they are performed translates into points:
  – Level 1: 25-49 points
  – Level 2: 50-74 points
  – Level 3: 75-100 points
Must Pass Elements

- **1B**: Managing Initial Referrals
- **1D**: Assessing Initial Referral Response
- **2E**: The Practice Team
- **4B**: Medication Management
- **6C**: Implement and Demonstrate CQI
PCSP Standard 1A

PCSP 1: Working With Primary Care and Other Referring Clinicians

The practice coordinates with primary care and referring clinicians to ensure timely information exchange.

Element A: Establishing Relationships With Primary Care and Other Referring Clinicians

The practice:

- [ ] 1. Works with frequently referring clinicians to set expectations for information sharing and patient care.
- [ ] 2. Has agreements with a subset of primary care or other referring clinicians.

Scoring

<table>
<thead>
<tr>
<th></th>
<th>100%</th>
<th>75%</th>
<th>50%</th>
<th>25%</th>
<th>0%</th>
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<tbody>
<tr>
<td>Score</td>
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Explanation

To promote effective communication and care coordination, specialists should establish relationships or agreements with primary care and other clinicians. Most specialty practices will have a range of clinical interactions or relationships with primary care and other referring clinicians, though the mix of interaction types may vary.

Specially practices of all types are expected to have a protocol for coordinating with primary care and other referring clinicians regardless of the type of specialty (e.g., procedure-focused, behavioral health, obstetrics-gynecology) or the nature of the specialty practice clinical interactions (consultative, referral and treatment, co-management or temporary or long-term principal care).

Factor 1: The practice collaborates with primary care practices and other referring clinicians on an ongoing basis.

Factor 2: The practice has jointly agreed-upon procedures (agreements) for working with referring clinicians.
### Element D: Assessing Initial Referral Response (MUST-PASS)

<table>
<thead>
<tr>
<th>No.</th>
<th>Description</th>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>Tracking when the referring provider was notified of the receipt of the referral and the time and date of the patient appointment.</td>
<td></td>
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<td>2.</td>
<td>Answers to clinical questions in the referral.</td>
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<tr>
<td>3.</td>
<td>Diagnosis.</td>
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<td>4.</td>
<td>Procedures and test results.</td>
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<td>5.</td>
<td>The specialist’s recommended plan of care.</td>
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<tr>
<td>6.</td>
<td>Follow-up needed with the specialist, including further coordination.</td>
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<tr>
<td>7.</td>
<td>Tracking and monitoring timeliness of referral response.</td>
<td></td>
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<tr>
<td>8.</td>
<td>Electronic transmission of a summary of care record to another provider, for more than 10 percent of referrals.+</td>
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</table>
Element E: The Practice Team (MUST-PASS)  

The practice uses a team to provide a range of patient care services by:

1. Defining roles for clinical and nonclinical team members.
   - Yes  No

2. Having regular team meetings or a structured communication process focused on patients.
   - Yes  No

3. Using standing orders for services.
   - Yes  No

4. Training and assigning members of the care team to coordinate care for individual patients.
   - Yes  No

5. Training and assigning members of the care team to support patients/families/caregivers in self-management, self-efficacy and behavior change.
   - Yes  No

6. Involving care team staff in the practice’s performance evaluation and quality improvement activities.
   - Yes  No

7. Holding regular practice team meetings.
   - Yes  No
## PCSP Standard 5B

### Element B: Referral Tracking and Follow-Up

<table>
<thead>
<tr>
<th>The practice coordinates referrals to other (secondary) specialists by:</th>
<th>Yes</th>
<th>No</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Consulting with the PCP and referring clinician and patient/family/caregiver regarding secondary referrals.</td>
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<td>2. Giving the specialist the clinical reason for the referral and pertinent clinical information. (CRITICAL FACTOR)</td>
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<tr>
<td>3. Tracking the status of the referral, including required timing for receiving a specialist’s report.</td>
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<tr>
<td>4. Following up to obtain the specialist’s report.</td>
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<tr>
<td>5. Establishing and documenting arrangements with specialists in the medical record, if co-management is needed.</td>
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<tr>
<td>6. Asking patients/families/caregivers about self-referrals and requesting reports from clinicians.</td>
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<tr>
<td>7. Ensuring that the PCP and the original referring clinician are notified of the secondary referral results.</td>
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<tr>
<td>8. Demonstrating its capability to provide an electronic summary-of-care record to another provider following a referral.</td>
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<tr>
<td>9. Electronically transmitting a summary-of-care record to another care provider, for more than 10 percent of care referrals.</td>
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<tr>
<td>10. Demonstrating its capability for electronic exchange of information with a recipient that uses different EHR technology.</td>
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6.00 points
Consult Orders

- Provide the clinical question including timing and type of referral

**Urgency/Timing**

- **Types**

**Clinical Questions**
Relevant Clinical Information

• Clinical Information
  – Diagnoses
  – Reason and evaluation details
  – Clinical findings
  – Medications
  – Current treatment
  – Current care plan
  – Follow-up communication
No appointment

Consult report lost or misfiled

Waiting until follow up visit to review results

No consult report sent

Not enough information from PCP

Provider booked out for weeks

Patient forgets referral order

Patient misses appointment

Authorizations
Co-Management

• Agreement between providers who regularly treat a patient
• Timely sharing of information
• Medical record documentation of plan
Lessons Learned from PCMH

- Culture
- Change management
- Leverage and involve HIT
- Celebrate small wins
- Train, reinforce, coach
- Accountability
Achieving Transformation

• Practice Culture
• People, Process, and Technology
  – Ensure awareness, desire
  – Knowledge and ability
  – Potential obstacles and risks
Change isn’t Easy

• The transformation process can be a long and difficult journey
• Teamwork
Achieving Transformation

• Understand current state
• Develop plan
• Create components
• Implement, train, and engage
• Plan Do Study Act (PDSA) cycles
• Submission preparation
Current State vs. Standards

- Policies and procedures
- Culture and environment
- Team structure
- HIT functionality
- Reporting capability
Improvement Cycles

- Act
- Plan
- Study
- Do
Workforce Engagement

• Inclusive
• Communication
• Training
• Consistently monitor progress and compliance
Recap

• Time of change
• Payment reform
• Collaboration is key
• Medical neighborhood growth
KEY TAKEAWAYS/ACTION ITEMS
Specialists –
Optimize Our ACO Performance

• **A**nnually encourage patients to see their PCP

• **C**ommunicate closely with PCP on quality initiatives

• **O**ptimize Referral agreements
Key Takeaways/Action Plan

• C – Connect back to Primary Care
• A – Accountability
• R – Referral Agreements
• E – Enhance communication
QUESTIONS
Announcements

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