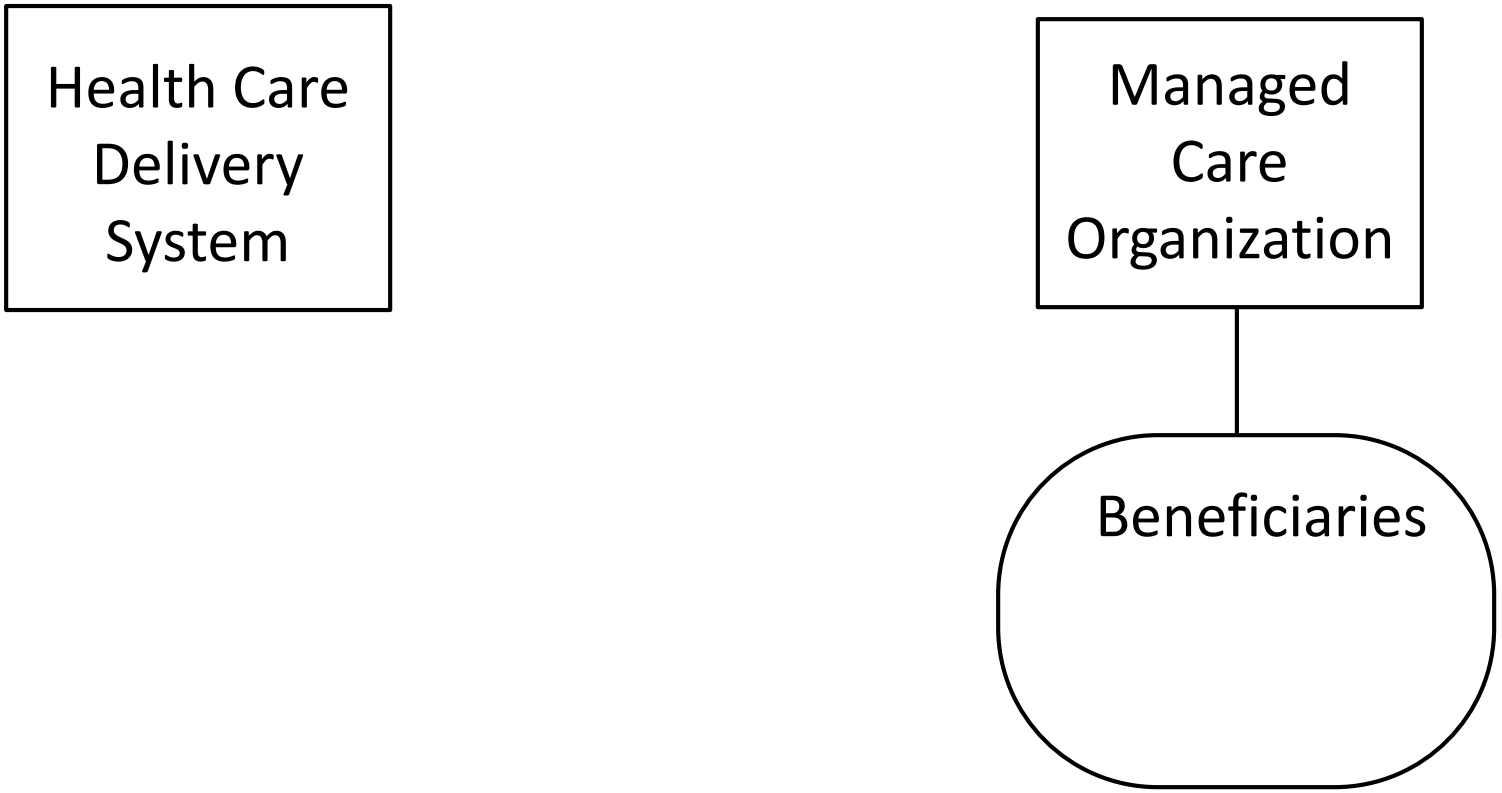
My Organization's Performance Story Under Value Based Payment

It's not just numbers,
it's a story about my patient populations.

What is performance?



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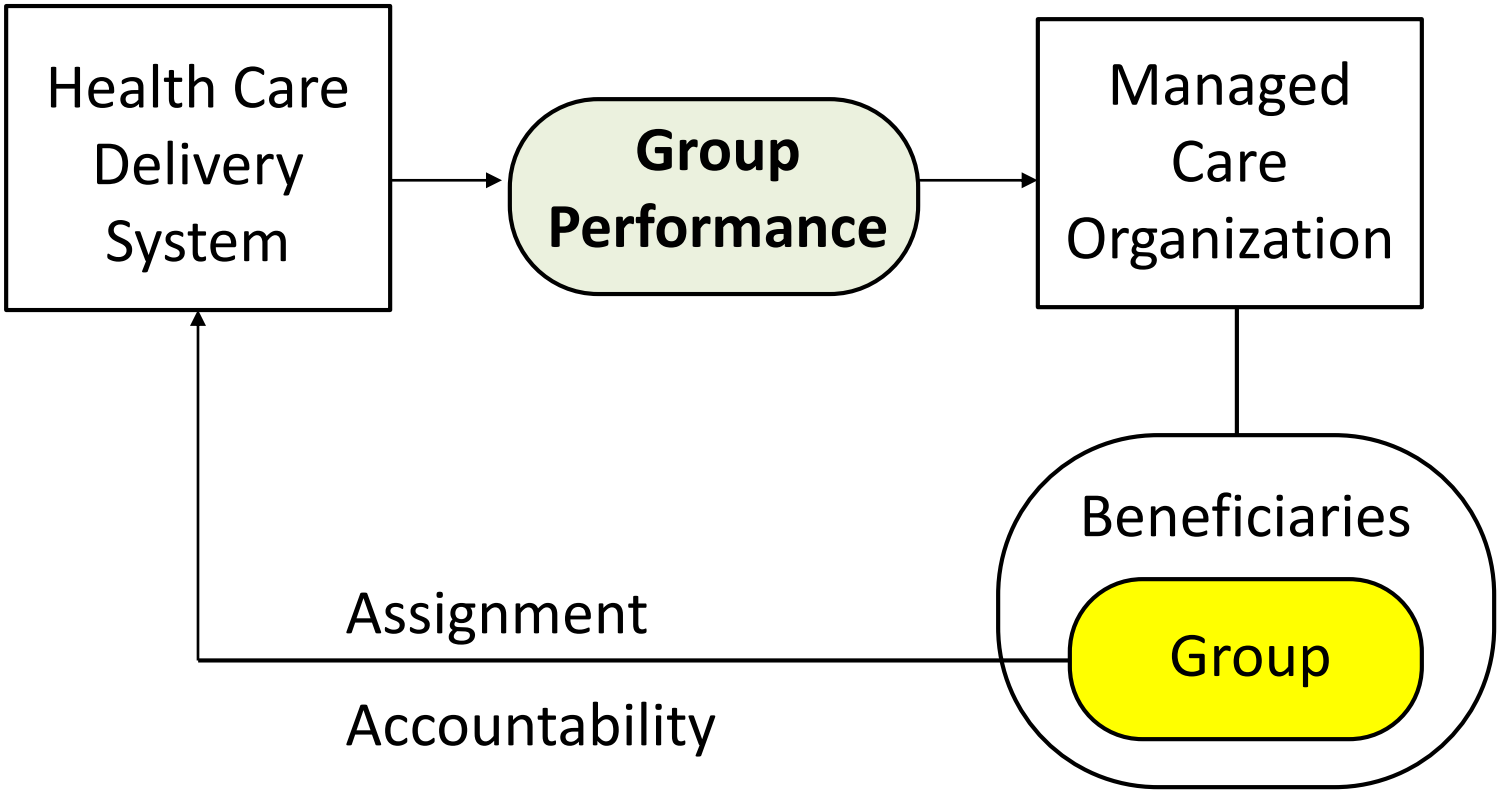

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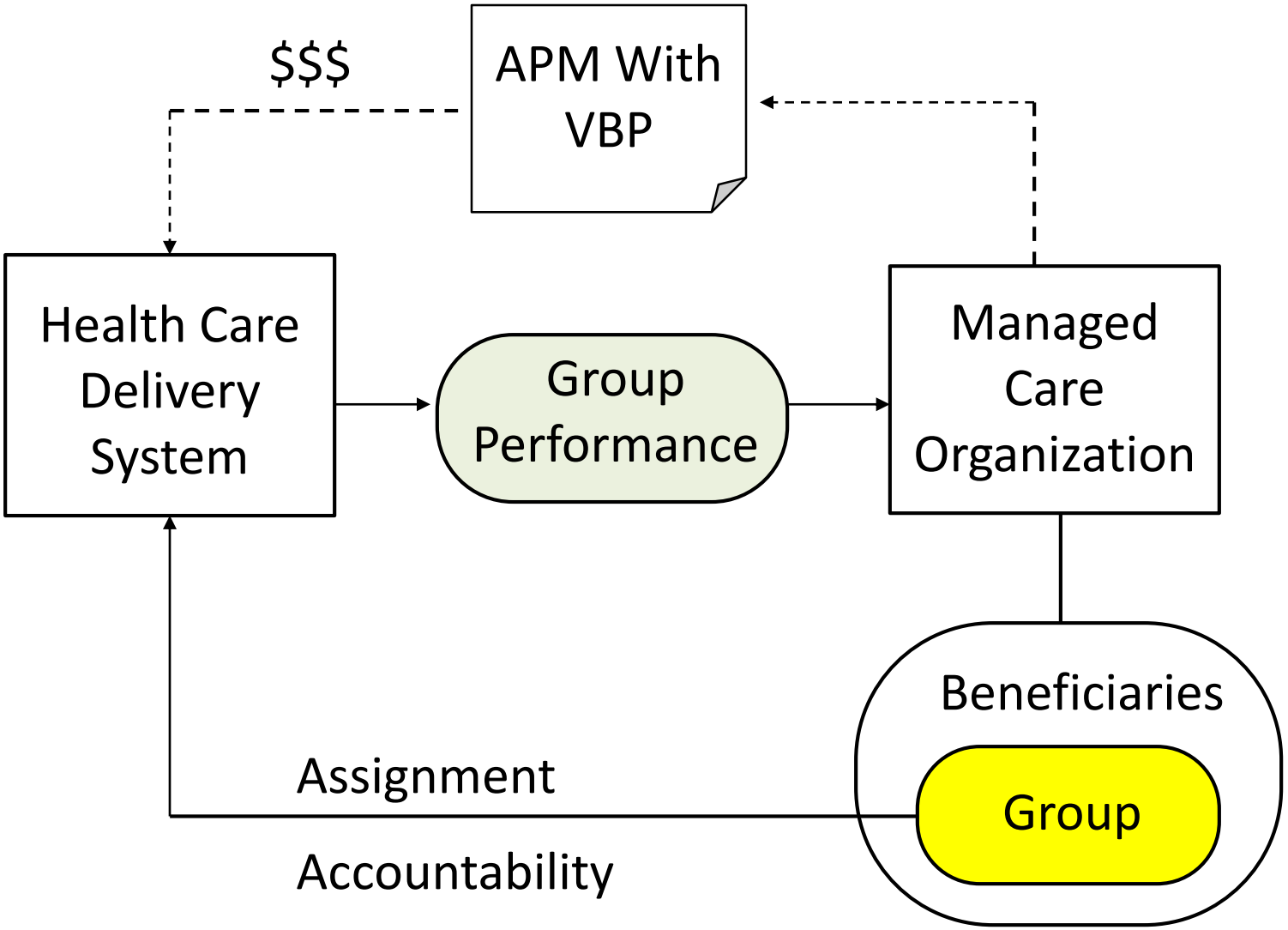

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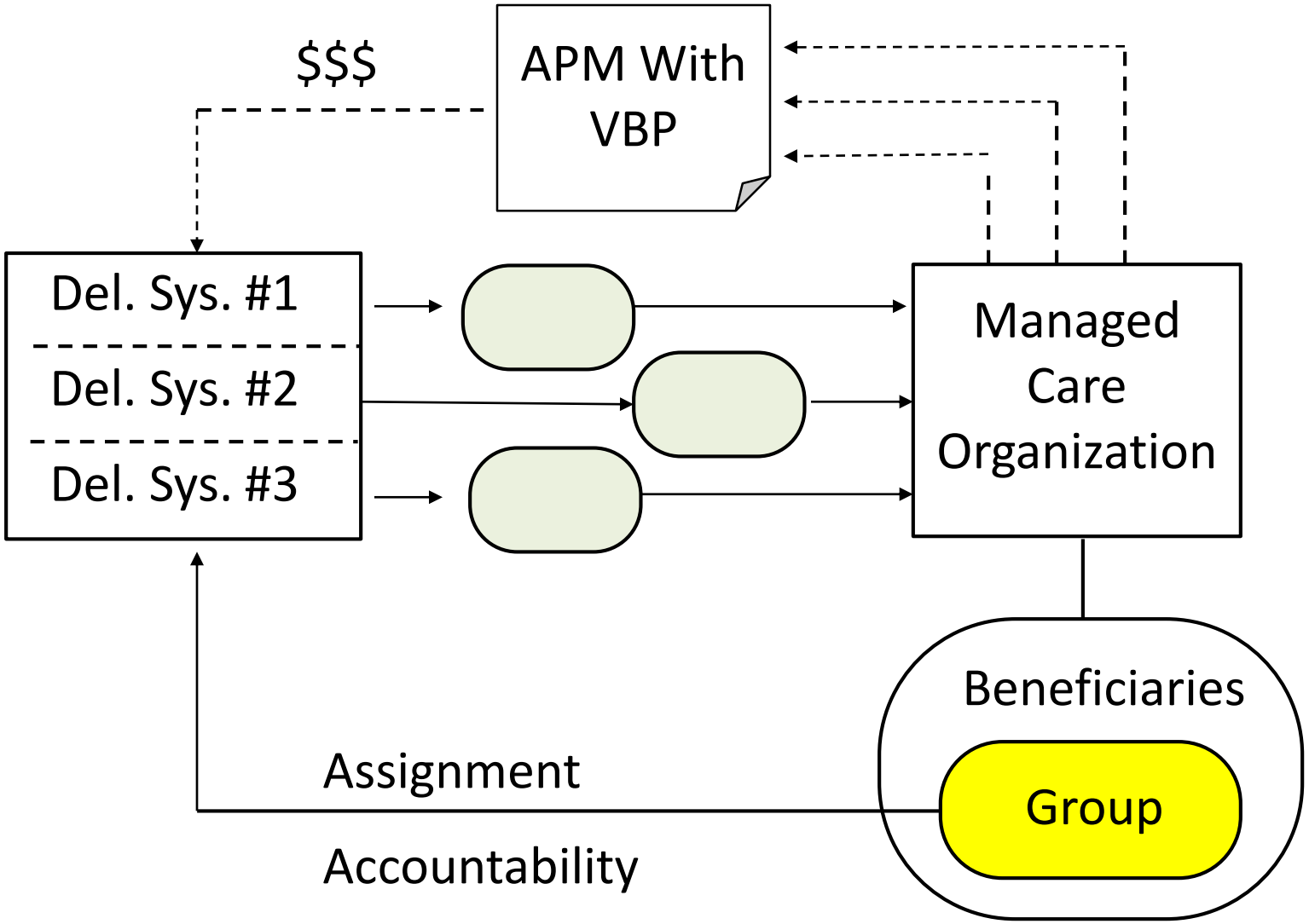
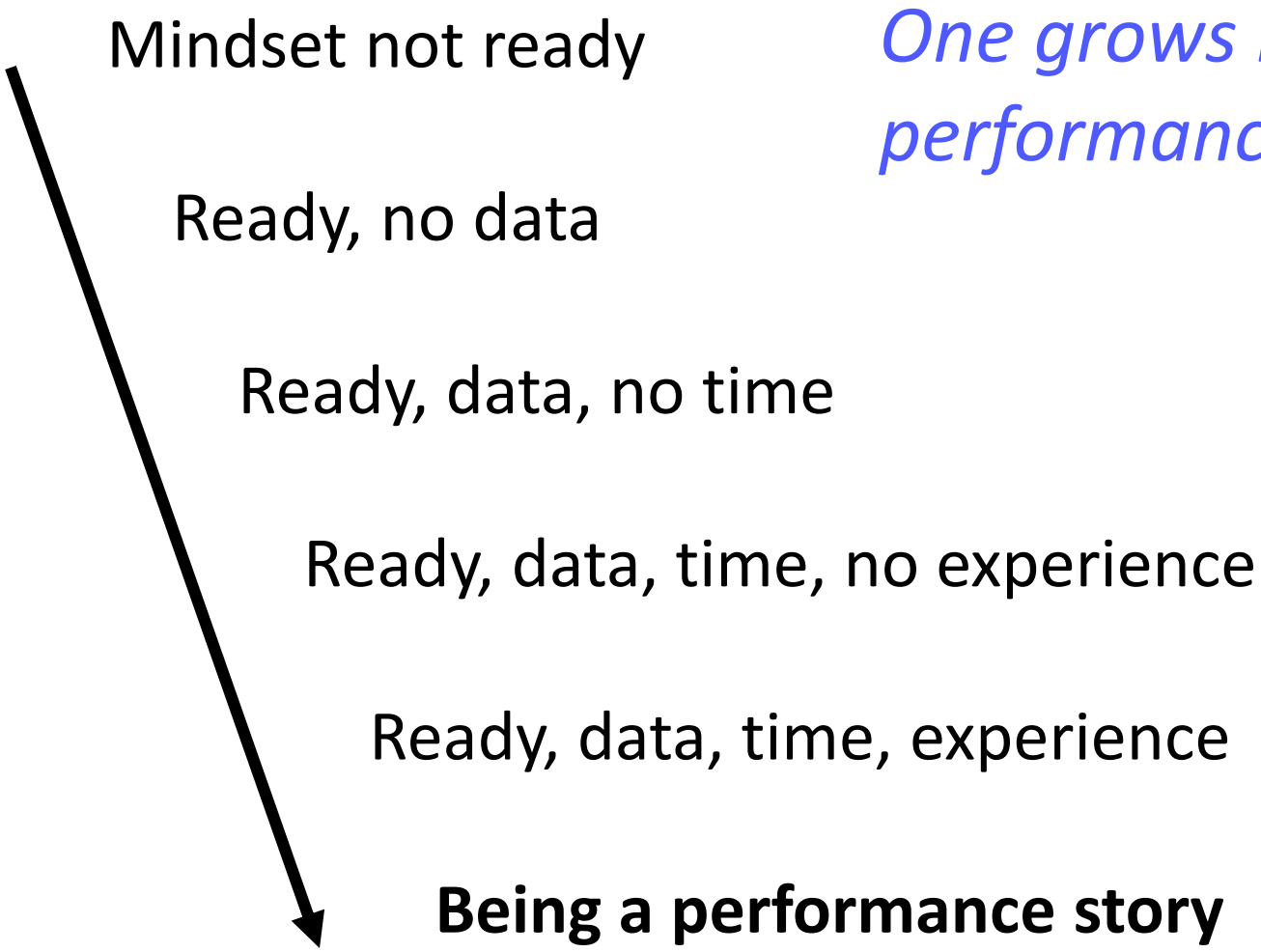




One grows into a performance story

The Whole

The Pieces

The Extraordinary

The Whole	**25,000**
The Pieces	**6 groups**
The Extraordinary	**400 women, high risk low birth weight**

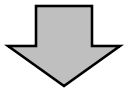
Transforming Clinical Practice Initiative

"Four Performance Domains We Want To Purchase"

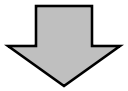
- Health Outcomes At Benchmark
- Reduced Unnecessary Hospitalizations
- Reduced Unnecessary Test and Procedures
- Savings To Payers

TCPI Change Package

3 Primary Drivers

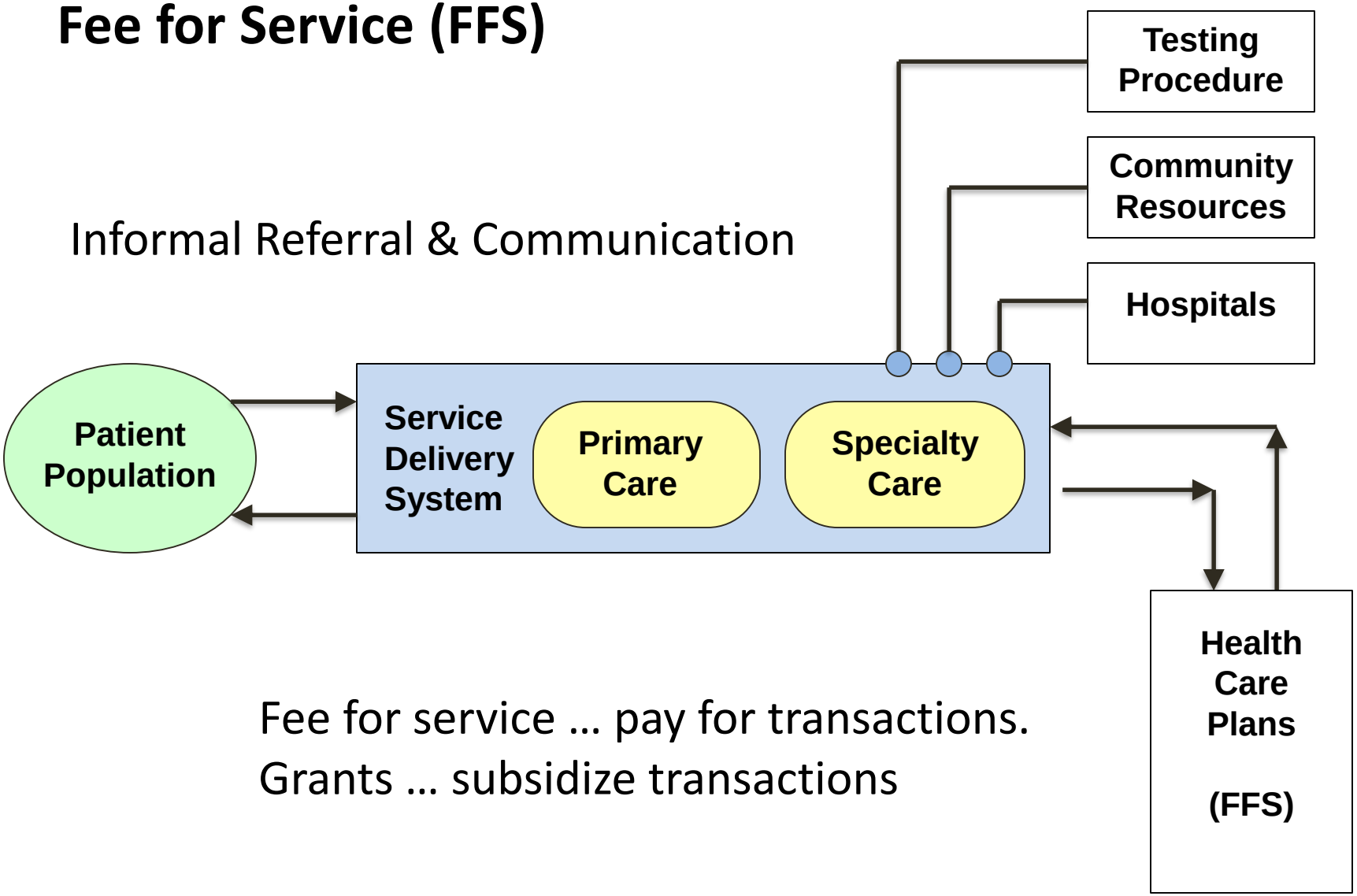


15 Secondary Drivers



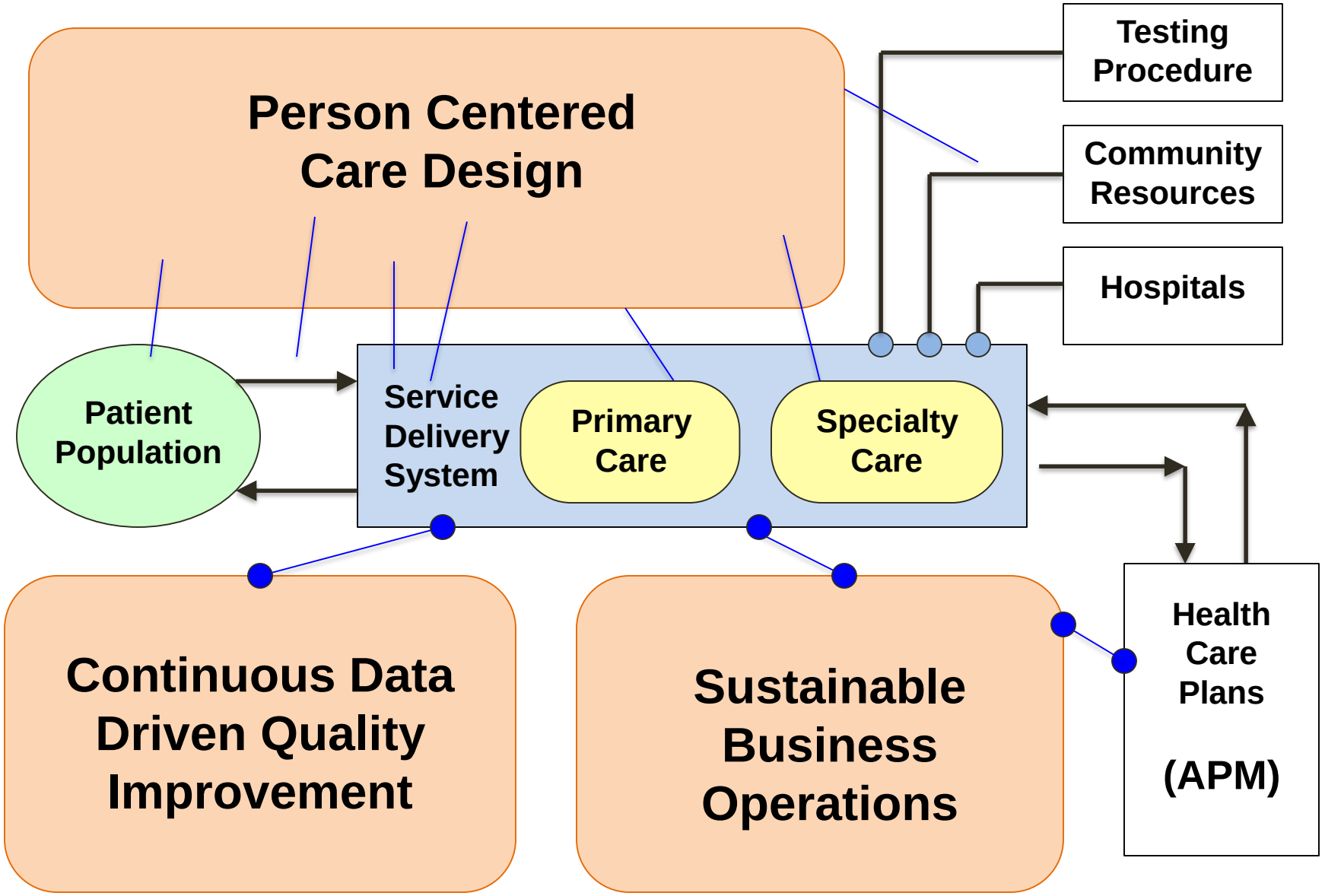
64 Change Concepts

Traditional Service Delivery System
Fee for Service (FFS)

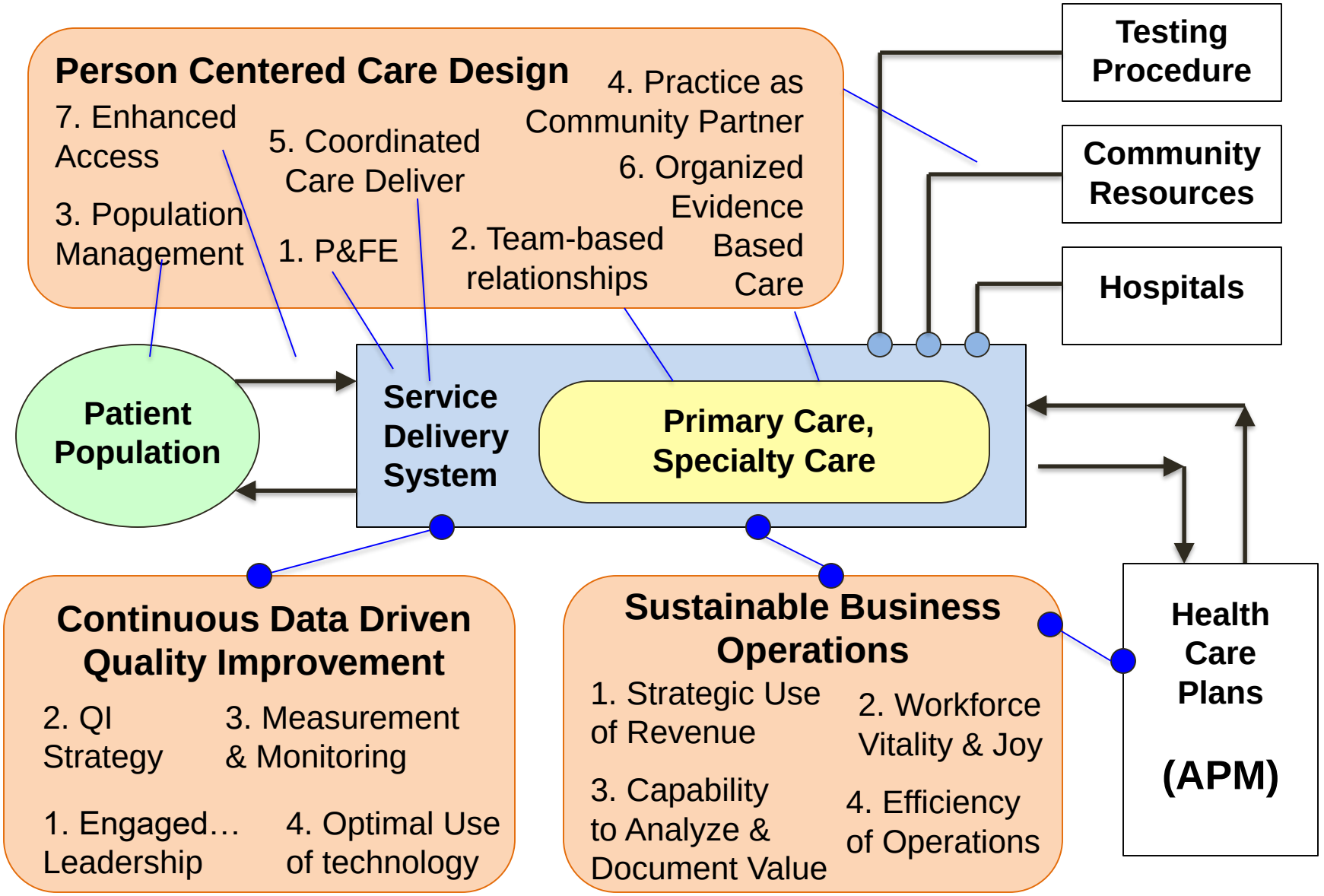


Fee for service … pay for transactions.
Grants … subsidize transactions

Transformation --- Create a Market for Value



Transformation --- Create a Market for Value



Person and Family-Centered Care Design Change Concepts

1.3 Population Management

a. Assign to Panels
b. Assign Accountability
c. Risk Stratify
d. Develop Registries
e. Identify Care Gaps

1.5 Coordinated Care Delivery

a. Manage Care Transitions
b. Establish Medical Neighborhood Role
c. Coordinate Care
d. Ensure Quality Referrals
e. Manage Medication

The Whole	25,000
The Pieces	6 groups
The Extraordinary	400 women, high risk low birth weight

Well-Defined Patient Population Groups
Each With A Unique Service Delivery System

Community Care Of West Virginia
Sarah Chouinard, MD, CMO

41,000 Patients (2018)

- 25,000 Long term, medical home
- 10,000 School based program
- 6,000 Episodic

Table 1: Population Management Performance Status on 24 Clinical Quality Measures (August 2018)				
Type of Measure	Meeting Benchmark (meet or exceed target)	Rapidly Improving (> 20% increase over 12 months)	Steadily Improving (>10% & < 20%)	Not Improving
Diabetes	3	0	4	0
Preventive	5	1	8	0
Utilization	1	2	0	0
Total Measures	***9***	***3***	***12***	***0***

Performance Domain	Measurement	Size of Population	Benchmark	Performance 2018
	Diabetes (7 Measures)			
	Prevention (14 measures)			
	Utilization (3 measures)			

Perform-ance Domain	Measure-ment	Size of Population	Bench-mark	Perform-ance 2018
Diabetes Outcomes	A1c < 9	2,774	84%	74%

Perform-ance Domain	Measure-ment	Size of Population	Bench-mark	Perform-ance 2018
Diabetes Outcomes	A1c < 9	2,774	84%	74%
Depression Screen	PHQ9	15,051	95%	86%
Children URI	Avoid Antibiotic	795	100%	99%

Table 2: CCWV Population Based Clinical Quality				
Performance Domain	Measurement	Patient Population in Need	Benchmark Target (% at clinical goal)	August 2018 Performance
Clinical Quality: Clinical Outcomes				
Diabetes Outcomes	A1c < 9	2774	84%	74%
	A1c < 7	2774	88%	42%
	BP <140/<90	2620	57%	76%
	LDL <100	2774	58%	48%
Clinical Quality: Clinical Process				
Diabetes Process	A1c Screen	2774	71%	90%
	LDL Screen	2774	58%	82%
	Eye exam	2774	59%	40%
Clinical Quality: Adult – Childhood Preventive				
Tobacco Cessation & Counseling		12093	95%	100%
HIV Linkage to Care		4	95%	100%
Child Weight Assessment & Counseling		8658	95%	99%
Adult Body Mass Index		22,204	70%	98%
Hypertensive BP Control	<140/<90	7,371	61%	78%
Asthma Action Plan		259	95%	83%
Breast Cancer Screen	Mammogram	4,790	81%	64%
Cervical Cancer Screen		8,087	93%	59%
Colorectal Cancer	Colonoscopy, FOBT or other	8,348	71%	59%
Pneumonia Vaccination		3,812	90%	72%
Advanced Care Plan	Advanced Direct-ives & MPOA	21,113	95%	52%
Depression Screening	PHQ2/9	15,051	95%	86%
Fall Risk Screening		3,578	95%	73%
Ischemic Vascular Disease/Use of Aspirin		1389	95%	82%
Clinical Quality: Health Resource Utilization (Avoid unnecessary use)				
Children with URI	Avoid antibiotic	795	100%	99%
Adults bronchitis	Avoid antibiotic	2,055	75%	85%
Low back pain	Avoid imaging	808	100%	82%

Diabetes Patients = 2,774 (from 25,000)

Target, % with A1C < 9 = 2,330 (84%)

Actual, % with A1C <9 = 2,053 (74%)

Short Fall = 2,330 – 2,053 = 277

Outreach efforts will enable CCWV to close 277 patient shortfall and bring population performance to 84%.

Diabetes Patients = 2,774 (from 25,000)

How close to perfection?

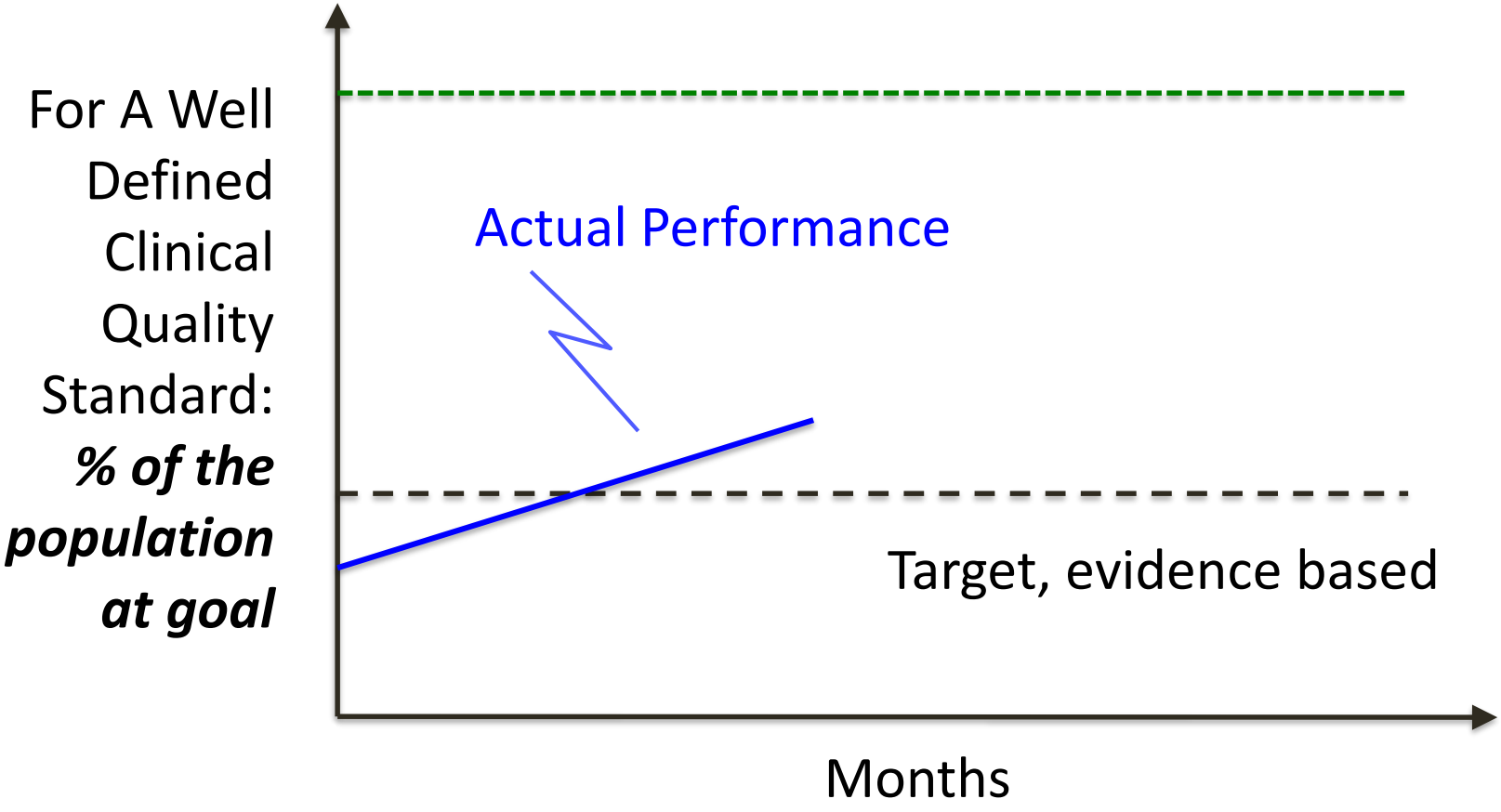
2,774 - 2,053 = 721 (not at goal)

- 447 = A1c > 9
- 274 = No recent labs

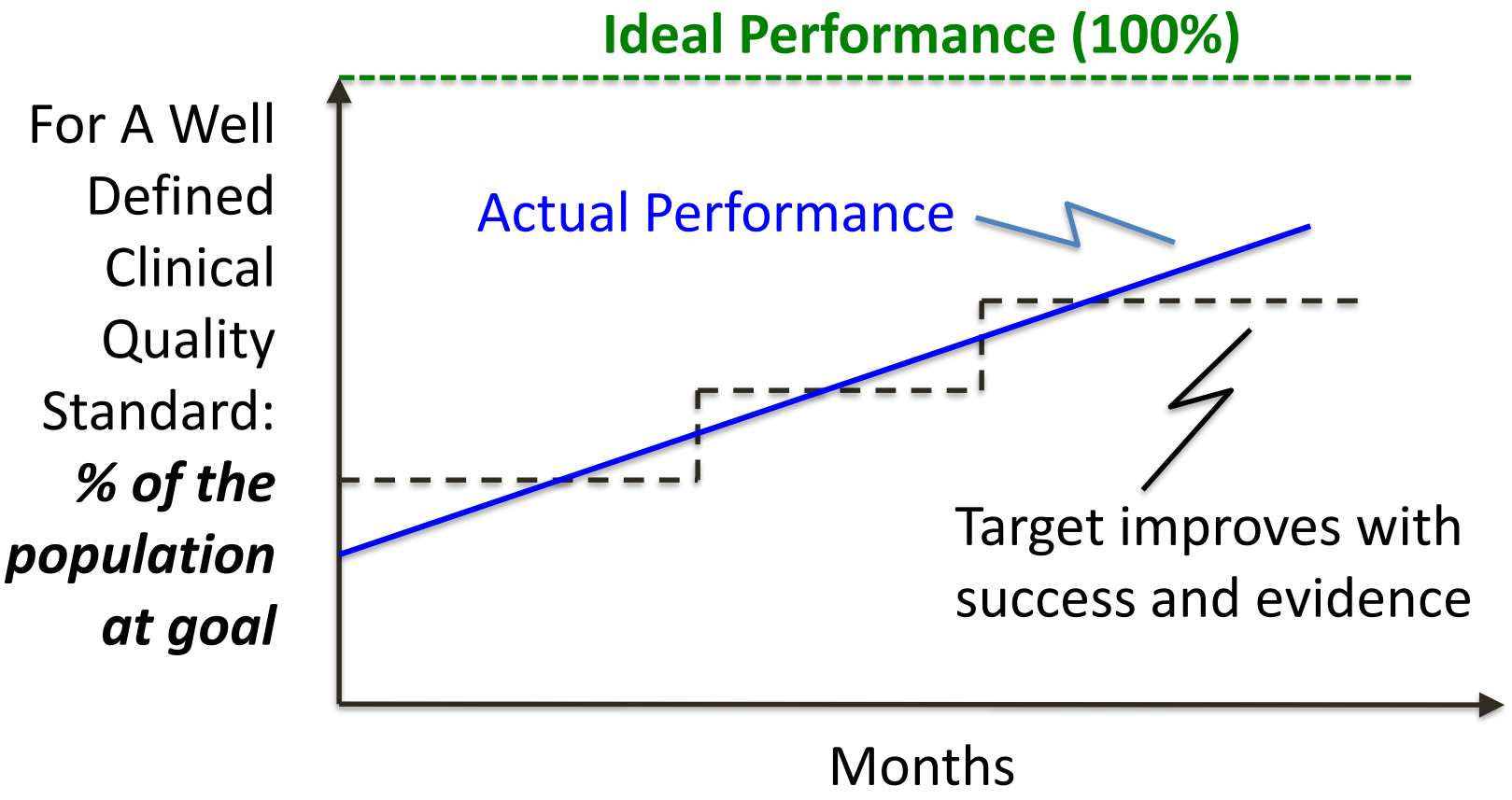
The 274 patients are typically using CCWV as an access point, but have a medical home outside CCWV.

- ***2,774 - 274 = 2,500 (our true accountability)***
- ***2,500/2,774 = 90% = ideal target (perfection)***

The performance model:



Our performance model:
a relentless march to ideal (perfection)



The Whole ---------- **25,000**

The Pieces ---------- **6 groups**

The Extraordinary ---------- **400 women, high risk low birth weight**

- ***Measure***
- ***Clinical Standard For Patient***
- ***Benchmark Population Target,***
  % Of Patient Group At Clinical Standard

Our preventive measures

"Benchmarks were set in accordance with **Healthy People 2020** goals unless the practice made a decision to raise the bar above that target. Nine of the 14 benchmarks are from HP2020. We **raised the bar above HP2020** on the other 5 measures because current performance already exceed their target."

"On 5 measures, we **exceeded benchmark**. On all others we are **steadily improving**.

"Seven preventive measures are better than 80%. In communities where transportation and economic strain poses a barrier to accessing care, this **achievement is significant**."

Our preventive measures - Low Scoring

“The three cancer screening measures and Advanced Care Planning are the lowest values, falling between 52%-64%.

“These measures require patient engagement, not just practice transformation.

“While still below target, **steady improvement has been made on every measure since 2015**. For example colorectal cancer screening has increased from 47% of our medical home patients screened in 2015 compared to 59% in 2018. “

"Health care utilization measures are powerful because they demonstrate money and time saved.

According to the CDC, 1 in 3 antibiotic prescriptions is unnecessary.

Tracking these measures became important to our practice, when in 2015, we had over 40% of children and 35% of adults receiving unnecessary antibiotics for viral illnesses.

Once we transformed our practice, of 795 children who had a viral infection, only 8 children received an antibiotic, a 99% success rate in keep children off of unnecessary medications. Our target is 100% …"

Table 3. CCWV Population Based Service Quality				
Performance Domain*	Size of Patient Population Involved	Measurement	Benchmark Targets	August 2018 Performance
No show	41,000	No show/day	<10%	7.5%
Open Access	41,000	% open slots at start	>20%	22%
Patient/hour	41,000	Patient seen/hour	=3	2
Patient E-mail Collection	41,000	% with address	>50%	47%
Portal Adoption	41,000	% enrolled	>50%	36%
Patient Cycle Time	41,000	Check in to check out	<45 min	41 min
Accounts Receivable	41,000	Days to payment	<6 days	5 days
Time Documents Open	41,000	Time note unsigned	<2days	1.26 days
Encounter Closed	41,000	Same Day Rate	>80%	81%
Average Panel Size	41,000	# Per Provider	=1200	1181
Referral Patient Sat.	41,000	Satisfaction	>80%	93%
Clinical Pharmacy Services On Request	601	% referred patients contacted	100%	100%

Table 4. Performance Based Payment Programs In 2017				
Payment Source	Type of Patient Population	Number of Patients	The Performance Resulting in Additional Payment	Additional $$$ Awarded
WV Family Health	Medicaid	1106	Achieving Quality Benchmarks	$47,000
Unicare	Medicaid	3042	Achieving Quality Benchmarks Well Child Contest	$47,000
AETNA	Medicaid	176	ER Utilization	$47,000
Humana	Medicare	1242	Achieving Quality Measure Targets PMPM for PCMH	$75,000
PEIA	Public Employees	2285	Reducing cost per patient through decreased ER utilization, reduced admissions, generic prescribing, and reducing unnecessary test.	$169,000
BCBS	Private	5431	Meeting Quality Benchmarks, Total Cost PMPM, ER Utilization, and Generic Prescribing.	$216,000
HRSA QI Awards	All Patients. (Overall practice transformation)	41,000	Clinical Quality Improvers; Health Center Quality Leaders; Advancing Health IT; Achieving PCMH	$263,000
Carelink	Medicaid	749	Meeting Quality Benchmarks and ER Utilization	$75,000
Total				***$939,000***

“Payers are attracted to CCWV because our data shows high *clinical quality* and robust *service quality*.

“This proof of performance positioned us to request additional payment, or a share of savings realized by payers.

Key to these negotiations is asking payers for their baseline cost data for the members we serve.”

“Our participation in incentive programs with payers has become a significant revenue stream.

The additional performance-based payments totaled $939,000 over 24 months.

Annual revenue is on the order of $30M.“

Gynecological Practice,
Lakewood Colorado
One MD
Three MA, Part Time NP, Part Time BH Provider

"… a blend of primary care and specialty care"

"… a forward-thinking women's medical practice designed to help women take charge of their own health .."

" … the 'go-to' place where women can swing by and get things done by people they know and who care."

Gynecological Practice
One MD
Three MA, Part Time NP, Part Time BH Provider

Empanelled Patients	5,437
Plan To See, 2018	2,009
Seen in 2018	2,496
New Patients, 2018	563

Most patients need screening every three years = screen 1/3 of empaneled patients per year

Year = 2018				
Empanelled Patients = 5,437				
Patients Seen = 2,496				
			Eligible, Expected	**Actual Screenings**
A.	**Screening (age group)**			
		PAP (21 - 65)	2,009	1,273
		STD/STI (< 26)	762	487
		Incontinence (> 40)	128	121
		BMI (all)	2,496	2,079
		Depression (all)	908	844
				Cases
B.	**Vaginal Bleeding**			156
C.	**Post Cancer Surveillence**			14
D.	**Surgery**			43
E.	**Birth Control Visits**			591
F.	**Urgent Care ("911")**			199

Year = 2018							
Empanelled Patients = 5,437							
Patients Seen = 2,496							
	Eligible, Expected	Actual Screenings	Abnormal Results	Abnormal Rate	Follow up	Follow Up Rate
A. Screening (age group)						
PAP (21 - 65)	2,009	1,273	196	15%	190	97%
STD/STI (< 26)	762	487	8	1.6%	8	100%
Incontinence (> 40)	128	121	24	21.6%	24	100%
BMI (all)	2,496	2,079	901	43%	811	90%
Depression (all)	908	844	673	80%	423	63%
		Visits				
B. Vaginal Bleeding		156				
C. Post Cancer Surveillence		14				
D. Surgery		43				
E. Birth Control Visits		591				
F. Urgent Care ("911")		199				

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BMI (all)	2,496	2,079	901	43%	811	90%
Depression (all)	908	844	673	80%	423	63%

Our value proposition for insurance companies

We are ready for APMs

Our bottom line is your bottom line

Our focus = superior patient experience.

Our 2018 estimated cost savings = $458,257

- 199 same day “911” visits in office; potential Emergency Department visits avoided = **$257,908 savings**
- 90% abnormal vaginal bleeding treated with medication, not surgery
- Expected savings for 2019 for generic hormone IUD insertion = **$72,000 savings**
- Length of stay for vaginal and laparoscopic assisted vaginal hysterectomy in 2018 averaged 2 hours = **$124,128 savings**

Building a System of Care by Building Connections and Relationships

The Journey of a Transformed Specialty Practice

Western Slope Endocrinology

- Solo Private Practice
- Grand Junction, Colorado
- One physician, two staff
- ~ 1600 patients
- Adult Endocrinology/Pediatric Diabetes & Thyroid

The Journey started with Discontent with Disconnected Care

- " Most of the time I don't know what the referring doc wants me to do for the patient"
- *"They had testing done but we don't have the results so since the patient is here now for a consultation, we'll just repeat the testing."*
- *"I don't know if my patient saw the specialist or not"*
- "Why didn't someone let me know they were referring my patient to a surgeon"

Survey on Referrals to my practice:

~50% of the time:

- ✓No records/no relevant data
- ✓No reason for referral stated
- ✓Patient didn’t know why they referred

A Specialty Practice Transforms Referral System

Care Coordination Agreements,
A Unilateral Approach

Referral Form For Referral To WSE.
"This is how we agree to work with those who refer to our center/practice and this is what we would like from you when you refer a patient "

Pre-Consultation – Pre Visit
E – Consult
Virtual Co-Management

Next: Step Back and Track Performance

Increase Quality of Referrals

- Basic Data
- Reason for Referral/Clinical Questions
- Pertinent Data

Reduce Wait Time for New Patients

Avoid Unnecessary Testing

Avoid Unnecessary Office Visit

PeaceHealth Medical Group
Robin Virgin, MD
Eric Blake, Director of Operations

Reducing Utilization & Improving Chronic Disease Management with High-Risk Care Management (HRCM)

PeaceHealth Medical Group

3 States
10 Hospitals
Multi-Specialty Group

224,000 Patients
306 Primary Care Providers
41 Clinics

High Risk Case Management

22,000 at risk patients (out of 224,000)

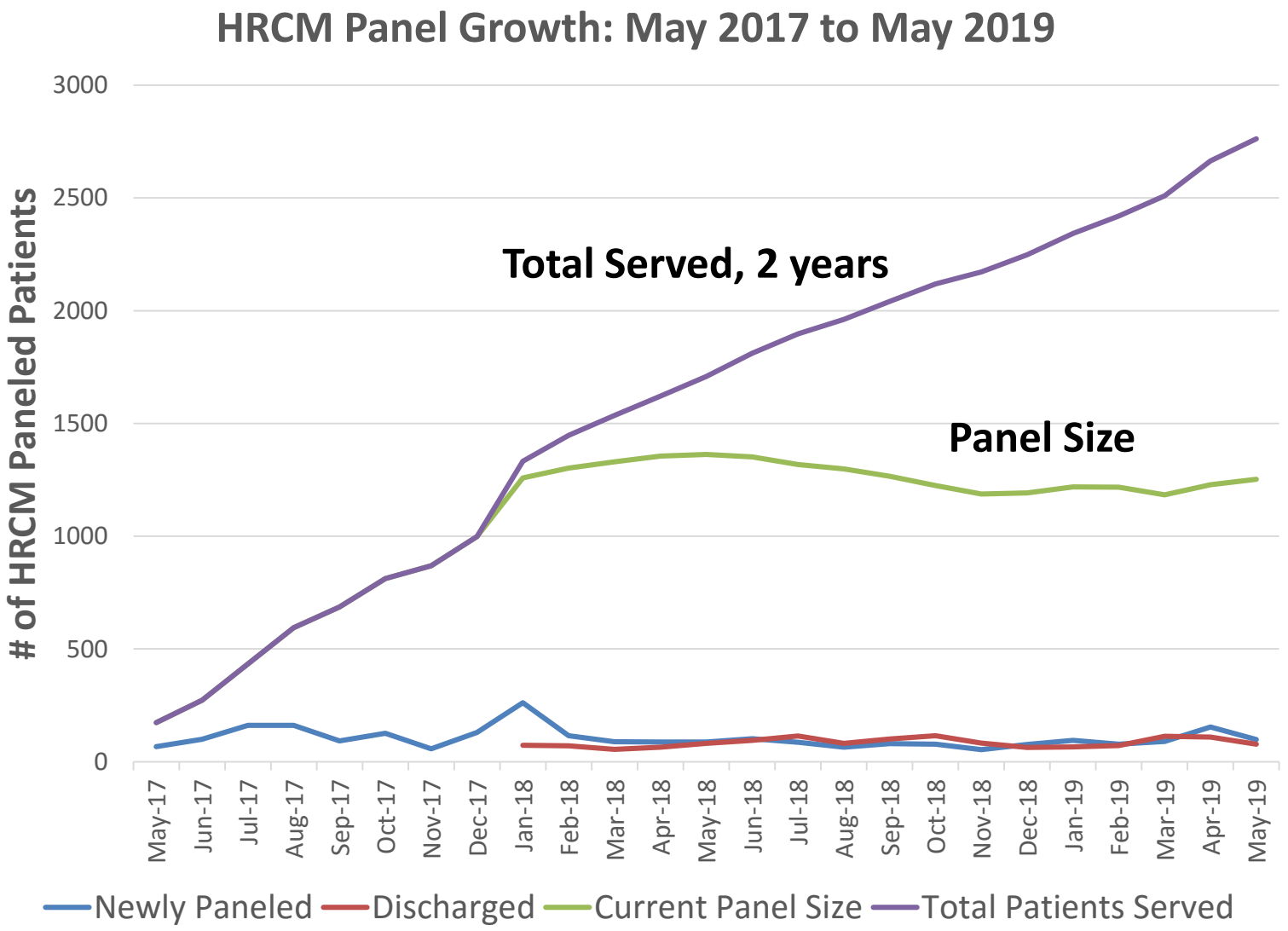
6,370 high risk patients

Risk Level	# of Patients	% of Patients
Low	176317	89%
Moderate	15190	8%
High	6370	3%
Total	**197877**	

- Number of Chronic Conditions
- Number of Medications
- Hospital admissions
- Medicaid
- Social Determinants of Health

High Risk Case Management

- Centrally Managed
- 7 regional teams
- 79 FTE: RN, SW, LPN Care Coordinators
- Current Capacity = 4,800 patients enrolled
- Enrollment (2019) = 1,200
- Length of Stay = 52 weeks


HRCM Panel Growth: May 2017 to May 2019
# of HRCM Paneled Patients
3000
2500
2000
1500
1000
500
0
Total Served, 2 years
Panel Size
May-17
Jun-17
Jul-17
Aug-17
Sep-17
Oct-17
Nov-17
Dec-17
Jan-18
Feb-18
Mar-18
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Newly Paneled
Discharged
Current Panel Size
Total Patients Served

$15,321,000 savings in avoided Hospital & ED visit (2 years, May 2017 to May 2019)

PeaceHealth HRCM As an Exemplary Practice PeaceHealth = 224,000 paneled primary care patients. HRCM = 2976 Patients receiving services since May 2017						
Areas of Avoidable Utilization	Total High Risk Patient Group (#)	# Currently Enrolled & Discharged from HRCM	HRCM Impact on Hospital Utilization			
			Historical Rate for HRCM Panel Admit/Pt/Yr	Current Rate Admit/Pt/Yr	Avoided since May 2017	Rate of reduction
In Patient Admissions & Readmissions	22,000	2976	1.16	0.845	938	27.2%
ED use	22,000	2976	1.47	1.29	515	11.7%

INSIGHTS from growing performance stories

1. A performance story is different than an improvement story.
2. Focus on results rather than the journey.
3. Develop first person stories that are compelling and exciting to read.
4. Start with entire population served, break out segments being managed.
5. Acknowledge significant progress toward a population management approach.
6. Extend story of process measures & clinical guidelines to capture value.
7. Use population targets that set benchmarks, not simply a level of improvement.
8. Draw data from management information systems driving performance.
9. Combine the use of text and tables to present performance with clarity.
10. Make the numerical statements of performance clear and complete.
11. Note patient ownership of and satisfaction with performance.
12. Note payers purchasing the Exemplary Practice's performance.

The Whole

The Patients For Whom We Are Accountable

The Pieces

Patient Groups With Tailored Delivery Systems

The Extraordinary

Benchmark Population-Based Performance