BENEFIT ENHANCEMENTS
QUALITY MEASURES

Lewiston 01.23.2019

NGACO Benefit Enhancements for 2019

BENEFIT ENHANCEMENT	GENERAL INFORMATION	IMPLEMENTATION PLAN
3-Day SNF Waiver	Eliminates the requirement of a 3 mid-night inpatient stay before admission to SNF	March 2019 – establishing process with CMG and SJRMC
Care Management Home Visit	Allows providers to initiate two care management in home visits in a 90 day period that are not home bound, to supplement provider visits to support improved health outcomes following a provider appointment.	April 2019 – will work to identify process needs from CMG and SJRMC for implementation beginning in Feb
Post-Discharge Home Visit	Allows for 9 home visits in a 90 day period following an inpatient stay by licensed or certified personnel under the supervision of a provider.	April 2019 – will work to identify process needs from CMG and SJRMC for implementation beginning in Feb
Telehealth	Supports beneficiaries by allowing them to originate a synchronous telehealth encounter in their home with their provider.	TBD
Cost Sharing for Part B Services	Aim is to offer cost sharing support to reduce financial barriers for beneficiaries, to support adherence with treatment plans and improve health outcomes.	April 2019 – will require agreements with providers and process for reporting between providers and NWMHP
Chronic Disease Management Reward Program	Allows NGACOs to provide gift cards up to $75 annually to incentivize participation in chronic disease management program.	April 2019 – will work to identify process needs from CMG and SJRMC for implementation beginning in Feb

Implementation Plan:
Benefit Enhancements

- Priority - SNF Direct Admission Process
  - Desire is Full implementation by March 2019
    - Dependent on decisions making by Executive Team to meet target for implementation
- Care management and Post-discharge visits
  - Require decision making with planned review during Feb visit
    - Who will be performing the visits
    - Verification of eligibility process
    - Documentation requirements
    - Billing/coding
    - Provider education

DIRECT SNF ADMISSIONS

Determination if candidate

- Eligibility Verification
  - Aligned to NGACO for the performance year admitted to the eligible SNF
  - Does not reside in a SNF or other long-term care setting
  - Is medically stable
  - Does not require acute level of care or further inpatient evaluation or treatment
  - Diagnosis indicating need is confirmed by physician
  - Evaluation by physician identifies a skilled nursing need *OR* rehabilitation need that cannot be provided as an outpatient

NWMHP: MANAGEMENT RESPONSIBILITIES

SNF DIRECT ADMISSIONS

- Prior authorization prior to SNF direct admission
- Monitor treatment plan
- Ensure engagement in Transitional Case Management program post discharge from skilled nursing facility
  - Needs assessment for complex care management
  - Care plan
  - Advance care planning documentation
  - Documented provider updates
- Satisfaction surveys following discharge
- Reporting to CMS quarterly

SJRMC – CMG DECISION MAKING

SNF DIRECT ADMISSIONS

- Skilled Nursing Facilities – Preferred Provider Network
  - Implement agreements with only the two selected SNFs
  - Implement agreements with those on approved list

- CMG / SJRMC level of participation in Care Management Services
  - During skilled stay
  - 30 – days post discharge

Protocols for Direct Admission to SNF

- Skilled Nursing Facility Requirements
  - Must have completed exam by physician within 24 hours of admission to the SNF
  - Care plan implemented within 24 hours of admission
  - Weekly review of beneficiary status during SNF stay
  - SNF will provide Primary Care Provider discharge notes within 7 days of discharge

- Education and training program for implementation
  - Waiver requirements
  - Communication plan
  - Patient evaluation and admission plan
  - Care management services

Protocols for Direct Admission to SNF

- Process for admission from home or outpatient setting
- Process for admission from inpatient hospital stay prior to full 3-day inpatient stay
- Process for informing beneficiaries about the waiver and their options for care settings

- Protocols are included in SNF agreements

Skilled Nursing Facility Responsibilities

- Comprehensive needs assessment within 3 days of admission
  - Identifies chronic diseases
  - Psychosocial barriers
  - Support system evaluation for discharge planning
  - Depression screening (PHQ-9)

- Care plan
  - Implemented within 24 hours
  - Updated to meet specific goals and interventions from needs assessments within 7 days from admission

Care Plan Development

- Problem List
- Expected outcome and prognosis
- Measurable treatment goals
- Symptom management
- Planned interventions and team members responsible
- Medication management needs
- Community and social services ordered
- Description of outpatient services and specialty care will be directed and coordinated
- Scheduled reviewed and revisions
- Include contact information for medical team

Communication – Use of Benefit

- Benefit option engagement process
  - Medical provider informs the beneficiary
  - Decision is between the provider and the beneficiary
- Following decision to participate in benefit
  - Provider to contact NWMHP for prior approval

Communication – Admission Process

- Completed Physician Admission Orders
- Signed Medication List
- New Hard Scripts
- Most Recent History and Physical
- Pre-Admission Screening and Resident Review (PASRR)
- Any scheduled appointments with providers / specialists

Communication – SNF Stay

- Care Plan – Copies to:
  - Beneficiary
  - Primary care provider
  - NWMHP
- Weekly updates of health status
  - Fax; call; or email updates per preference of provider
- Discharge planning
- CMG/SJRMC: provider preferences for updates and information

Post-Discharge Services

- CMG/SJRMC: Complex Care Management
  - Home visit within 3 days post discharge
  - Provide outreach based on risk stratification assessment
  - Implement Team-Based Binder
    - SNF or Care Management
  - Identify if eligible for other benefit enhancements

Questions and Complaints

- 24 hour phone line for questions
  - NWMHP on-call phone line to be provided

- 24 hour phone line for reporting complaints
  - Complaints are reviewed within 5 business days
    - If safety concerns are identified will be reviewed during next business day
  - Complaints are brought to Medical Directors for review
    - Trends and reporting to Physicians Advisory Committee of complaints as indicated
  - NWMHP compliance phone line to be provided

ACO Quality Measures

- **Total of 31 measures across all domains**

- **CAHPS (Consumer Assessment of Healthcare Providers and Systems)**
  - 8 Measures fall into Patient/Caregiver Experience
  - NWMHP will hire a vendor to complete the survey. Per CMS must be a validated vendor from their list. The vendor provides blinded results.

- **Claims Reported Measures**
  - 7 Measures fall into Care Coordination/Patient Safety

- **Manually Reported Measures**
  - Collected through medical record review
  - 2 Measures fall into Care Coordination/Patient Safety
  - 8 Measures fall into Preventive Health
  - 5 Measures fall into Clinical Care for the At Risk Population

Reporting of Quality Outcomes

- Data from all measures will be reported by CMS for the aggregate of the NGACO
  - Unknown % of patients of from the two locations

- 15 of the 22 provider driven quality measures require manual submission of data
  - Data collection and submission will be done by PSW

CAHPS: Beneficiary Survey Measures	Ideas for Quality Initiatives to Improve Outcomes
Getting Timely Care, Appointments, and Information	Quality Improvement Initiative by Care Management Services to identify potential concerns for follow up
How Well Your Providers Communicate	Implement Team-Based Binder
Patient's Rating of Provider	Care management outreach services to identify potential emerging concerns
Health Promotion and Education	Referrals to Care Management Program to support health promotion and educational needs for beneficiaries
Shared Decision Making	PSW is currently developing educational materials for providers to address shared decision making
Health Status and Functional Status	Support dialog between beneficiaries and providers regarding health status – discussions for Advance Care Planning
Stewardship of Patient Resources	Shared decision making

Survey reporting process

- Vendor – DSS Research
  - Must be approved by CMS
- Beneficiary eligibility for survey
  - Assigned to ACO
  - 2 or more visits to primary care
  - 25% classified as high uses of services
- Pre-notification letter by the vendor is sent end of October
- Surveys are mailed the following week
- Vendor conducts telephone follow up calls December – January
- Survey is submitted to CMS end of January

NG ACO Quality Measures

Care Coordination and Patient Safety (10 measures)	Preventive Health (8 measures)	At Risk Population (5 measures)
All condition readmission	**Influenza Vaccination	**Depression Remission at 12 months
Skilled Nursing Facility 30-Day all cause readmissions	**Pneumonia Vaccination	**Hemoglobin A1c poor control
All-cause unplanned admissions for patients with diabetes	**BMI Screening and Follow Up	**Diabetes – Eye Exam
All-cause unplanned admissions for patients with heart failure	**Tobacco use: screening and cessation intervention	**Controlling Hypertension
All-cause unplanned admissions for patients with multiple chronic conditions	**Screening for Clinical Depression and follow up	**Use of Aspirin or other antithrombotic with diagnosis of Ischemic Vascular Disease
Ambulatory sensitive condition acute composite	**Breast Cancer Screening	
Use of Certified EHR Technology	**Colorectal Cancer Screening	
**Medication reconciliation post-discharge	**Statin Therapy for the Prevention and Treatment of cardiovascular disease	
** Fall Screening for future fall risk		
Use of Imaging Studies for Low Back Pain		

***those in red with asterisks are the measures that require manual review from EHR*

How can we help?

- Tools and resources used to for provider support to capture quality measures?
  - Specific measure description tools
  - Opportunities for patient services to meet measure requirements and improve health outcomes
    - Advance care planning
    - Annual Wellness
    - Intensive behavioral therapy for obesity
- Access to information for reporting purposes

Next Steps

- CMG / SJRMC decision making for implementation of SNF direct admits
- Process steps in place by CMG and SJRMC providers / office support staff
  - Example workflow provided – need feedback by team with Feb visit
- Agreements in place with SNF providers
  - Identify SNF providers
  - NWMHP will implement agreements
- Forms used across providers to meet protocols developed and education provided on use

Questions?