Quality Improvement Webinar Series: QI Opportunities & Resources

June 2, 2020

Health Partners Plans HPP

Agenda

- **Opening Remarks**
- **HPP's Quality Programs Overview**
  - Key Quality Programs
  - Key Priority Measures
- **Providers' Value Proposition**
  - Value Proposition Overview
  - Summary of CY2019 "Missed Opportunities"
- **Tools & Resources Overview**
  - Available Provider Tools and Resources
  - Current HPP Quality Improvement Activities
  - Overview of In-Home Services Offered by HPP
- **Recommendations**
- **Q&A**

Partnership 101

What do we look for in a partnership for quality improvement projects?

- ✓ **Engagement:**
  - Identify a quality champion at your office who can work directly with us on partnering initiatives and will be responsive and engaged.
  - Open to feedback, willing to act on the data and insight provided.
- ✓ **Understanding of your population, data & overall goal(s) of your organization:**
  - Review your data in advance to make sure initiatives will have an impact, and set realistic goals (# patients attempted, measure improvement).
- ✓ **Track record of quality-focused efforts:**
  - Already participating in various quality improvement activities & programs.

Key Quality Programs

HPP is committed to improving and maintaining our performance in the following programs:

Program	Description	Impact	2019 Results
Provider Pay-for Performance (QCP Program)	QCP is HPP's primary care physician incentive program that offers financial incentives to providers for select performance measures.	All	508 provider sites were rewarded
Patient-Centered Medical Home (PCMH)	A model of care program that enhances & facilitates care coordination.	Medicaid	78 sites that cover 44% of membership
NCQA Accreditation	Evaluates how well a health plan performs based on standards set by NCQA.	Medicaid	Commendable Status
NCQA Multicultural Distinction	Identifies plans that lead the market in providing culturally and linguistically sensitive services, and work to reduce health care disparities.	Medicaid	Awarded
NCQA Plan Rating	Plans are rated based on a scale from 0-5 based on a combination of clinical, quality, and member satisfaction results.	Medicaid	4.5 Plan Rating
CMS Stars Program	Health plans are rated by CMS based on a five-star scale on a set of 48 measures.	Medicare	3.5 Stars Rating
DHS MCO P4P Program	Measures HPP for meeting HEDIS benchmarks and/or improvement from previous year.	Medicaid	High Performer

Key Priority Measures

HPP has defined our 2020 measure level priorities based on historical performance and programs' goals and impact.

Priority 1 measures:

1. Lead Screening in Children (LSC)
2. Breast Cancer Screening (BCS)
3. Colorectal Cancer Screening (COL)
4. Chlamydia Screening in Women (CHL)
5. Care for Older Adults (COA)
6. Medication Management for People With Asthma (MMA)*
7. Asthma Medication Ratio (AMR)
8. Controlling High Blood Pressure (CBP)
9. Comprehensive Diabetes Care (CDC)
10. Osteoporosis Management in Women Who Had a Fracture (OMW)
11. Antidepressant Medication Management (AMM)
12. Medication Reconciliation Post-Discharge (MRP)
13. Annual Dental Visit (ADV)*
14. Prenatal and Postpartum Care (PPC)
15. Well-Child Visits in the First 15 Months of Life (W15)
16. Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)
17. Adolescent Well-Care Visits (AWC)
18. Medication Adherence for Oral Diabetes Medications (-)
19. Medication Adherence for Hypertension (ACEI or ARB) (-)
20. Medication Adherence for Cholesterol (Statins)
21. Developmental screening in the first three years of life (DEV)
22. Reducing Preventable Readmissions (PRP)

Priority 2 measures:

1. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)
2. Childhood Immunization Status (CIS)
3. Immunizations for Adolescents (IMA)
4. Cervical Cancer Screening (CCS)
5. Appropriate Testing for Children With Pharyngitis (CWP)
6. Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)
7. Pharmacotherapy Management of COPD Exacerbation (PCE)
8. Statin Therapy for Patients With Cardiovascular Disease (SPC)
9. Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)*
10. Follow-Up Care for Children Prescribed ADHD Medication (ADD)
11. Follow-Up After Hospitalization for Mental Illness (FUH)
12. Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)
13. Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)
14. Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)
15. Transitions of Care (TRC)
16. Appropriate Treatment for Children With Upper Respiratory Infection (URI)
17. Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB)
19. Use of Opioids at High Dosage (HDO)
20. Use of Opioids From Multiple Providers (UOP)
21. Risk of Continued Opioid Use (COU)
22. Medical Assistance With Smoking and Tobacco Use Cessation (MSC)
23. Pneumococcal Vaccination Status for Older Adults (PNU)
24. Adults' Access to Preventive/Ambulatory Health Services (AAP)
25. Children's and Adolescents' Access to Primary Care Practitioners (CAP)*
26. Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)
27. Ambulatory Care (AMB)
28. Inpatient Utilization—General Hospital/Acute Care (IPU)
29. Plan All-Cause Readmissions (PCR)
30. Prenatal Depression Screening and Follow-Up (PND)
31. Postpartum Depression Screening and Follow-Up (PDS)
32. Statin Use in Persons with Diabetes (SUPD)
33. MTM Completion Rate for Comprehensive Medication Reviews (-)
34. Dental Sealants for 6-9 year old children at elevated caries risk (SEAL)
35. Annual number of asthma patients with one or more asthma-related ED visits (ASM)
36. Contraceptive care - postpartum women age 15-20 & 21 – 44 (CCP-CH)
37. Contraceptive care - all women age 15-20 (CCW-CH)
38. adult annual dental visit (ADV-PAPM)

Note: Numbering system does not reflect priority level within each bucket.
*Measure expected to be retired in the next 1-3 years.
Can be prioritized during Covid-19 pandemic.

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Providers' Value Proposition

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Evolving care delivery and incentive models tied to quality programs have become critical to our provider organizations' success.

Financial Incentive: QCP Financial Opportunities

Per Member Per Month (PMPM) Payment				
	Tier 1	**Tier 2**	**Tier 3**	**Tier 4**
Medicare Total	$6.25	$11.75	$22.25	$32.25
Medicaid Total	$5.60	$9.90	$18.75	$26.25
CHIP Total	$2.70	$5.15	$9.05	$13.55
Total PMPM	**$14.55**	**$26.80**	**$50.05**	**$72.05**

Operational Opportunities

Growth	No-show Reduction	Abrasion Reduction
Increased Efficiency	Program Inclusion	Clinical Impact Improvement

Summary of CY2019 "Missed Opportunities"

Annually, HPP evaluates and shares data to identify missed opportunities for our providers. These "missed opportunities" are defined as members who were seen, but care gaps were left open.

Overall HPP Performance

Total # of members with gaps	Average # of visits to assigned PCP	# of members with 3+ visits with assigned PCP	Total # of gaps identified as missed opportunity
52,787	2.70	20,370	75,210

52k *members were seen an average of* ***2.7*** *times and had* ***75k*** *gaps left open.*

Total # of gaps identified as missed opportunity	Total # of easy gaps	Total # of medium gaps	Total# of hard gaps
75,210	16,284	40,629	18,297

22% *of gaps were considered easy gaps,* ***54%*** *were medium and* ***24%*** *were considered hard.*

Total # of QCP gaps left open	Total # of MCO P4P gaps left open	Total # of Stars gaps left open
57,997	32,122	13,236

Provider revenue generating opportunities left on the table.

Negatively impacts HPP's funding opportunities.

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Tools & Resources Overview

Provider Tools and Resources

HPP has various tools and resources available to our provider organizations.

Resource	Description	Frequency
Network Account Managers	Your main point of contact who can help support your practices, review reports with you and connect you to the right resources within HPP.	Ongoing
QCP Manual	Includes an overview of measures, best practices, codes for compliance and payout opportunities.	Annually
NaviNet Reports	Include membership data, eligibility reports, practice level reports, and gap-in-care (GIC) reports. Monthly site level report cards allow you to track your performance and opportunities.	Varies
Webinars	Cover various topics to help you provide the best outcomes for your patients.	Ad-hoc
Reporting /Data	HPP can provide your practice with reports to help with population health management, quality improvement activities, and utilization management.	Ad-hoc
Coding Education	HPP's Clinical Risk Assessment team provides education on appropriate coding and documentation.	Ongoing
Data Sharing	HPP's data and quality team can work with you to capture supplemental data from your EMR or to gain access to your EMR.	Ongoing

Quality & Population Health Reports Available on NaviNet

HPP has various reports available in NaviNet that are updated weekly, monthly, and quarterly.

Report	Description	Frequency
Member Roster Report	Member level report of all members attributed to your site, the date of members' last PCP visit and chronic conditions.	Monthly
Care Gap Report	Member level report of all open care gaps.	Monthly
QCP TIN/Site Level Report Card MQCP Report Card	Report of your QCP/MQCP program performance and payout.	Annually
QCP TIN Level HEDIS Report QCP Site level HEDIS Report	Report of your QCP quality measure performance at the TIN & site level.	Monthly
STARS TIN Level Report STARS Site Level Report	Stars measure performance report at the TIN & site level	Monthly
Medication Adherence Report	Member level report of medication adherence data for your Medicare members for Diabetes, Cholesterol and Hypertension medications.	Weekly
Medicare Overview Medicaid Overview	Summary report at the TIN level of your Medicare/Medicaid membership, medical costs, and utilization compared to total.	Quarterly
ER Report IP Report	Member level report of inpatient and emergency room utilization for your TIN/site.	Monthly
Diabetes Prevention Program (DPP Program)	Member level report identifying all members eligible for the DPP program.	Bi-Monthly

Current HPP Quality Improvement Activities

HPP often partners with provider & community organizations to further drive quality improvement, and improve access and member engagement.

Appointment Scheduling

HPP conducts outreach calls (internally and using vendors) to members to schedule appointments for all priority measures.

Educational Mailings

HPP conducts member mailings to educate on the importance of screenings and also mails screening kits (e.g., FOBT) to increase outcomes.

Health Screening Event Partnerships

HPP partners with practice sites on block scheduling events for select measures and partners with the Fox Chase mobile van to conduct mammogram screening events.

Quality Programs

BabyPartners, tobacco cessation, diabetes prevention, CX training and in-home medication dispensary programs have been created to help support our providers.

In-Home Services

HPP partners with various vendors including Quest, Matrix, Inovalon and the VNA to conduct in-home visits for members for well visits, diabetes testing, and other critical services.

Member Incentive Program

HPP offers a member incentive program for Medicare (reloadable gift card) and Medicaid (points to be used in a catalog) members for completing key health screenings.

These initiatives only highlight <u>some</u> of the opportunities offered to our network.

Overview of In-Home Services Offered by HPP

HPP offers in-home visits and screenings as a complimentary/additional way for patients to receive services they otherwise might not.
Please refer to the list of HPP's key vendor partners in the table below:

Vendor Name	Service(s) Provided
Matrix Medical (*****NEW*****)	• Health Risk Assessment Visits • Pediatric Well Visits • Lab Screenings • Bone Mineral Density Testing
Inovalon	• Health Risk Assessment Visits • Annual Well Visits
Visiting Nurse Association of Philadelphia (VNA)	• Postpartum Visits
Quest HealthConnect (formerly MedXM)	• Lab Screenings
Healthy Measures	• Lab Screenings
MedaCube	• Medication Dispensary Box

Please note that provider organizations have the ability to opt-out of these programs. In addition, a follow-up process is in place for handling any abnormal results.

Recommendation for Success

HPP recommends the following actions to improve your performance:

STRATEGY

- Talk to us about your challenges & needs. We can likely help or partner with you on quality improvement initiatives!
- Rethink your processes to address gap closure during every office visit (even sick visits) when possible.
- Review your missed opportunities and design corrective action plans and/or lessons learned documents.

ACTIVITIES

- Know your available resources (people, reporting, and tools).
- Ensure that you are using the correct codes for compliance (key codes are available in the QCP Manual).
- Use CPTII codes for measures that are results driven (some practices are automatically adding these to claims for certain triggers/results in their EMR systems).
- Ensure proper documentation in your members' charts, including specific exclusion reasons.

QUESTIONS?

Thank you for your participation!

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