Transitioning from Fee-for-Service to Outcomes Based Payments

Paul Reiss MD
Evergreen Family Health
Chief Medical Officer, Healthfirst IPA
Primary care expected to voluntarily provide many services beyond the encounter

- No payment for outreach, reminders, health maintenance (beyond visit), coordination of care

Practice incentives:

Maximize encounters and billing strategies, staff office for volume, increase efficiency of patient visits

But: incentive does get patients in for necessary visits, and pays for a definite volume of real work.
NON-FFS payments

Blueprint payments

- Base payment for NCQA PCMH recognition, working with a CHT, and sending practice data
- No funding to support practice transformation
  - Est costs >$50,000/FTE
- How much is enough to adequately support ongoing practice resources required?
  - >$100,000/Yr/FTE physician

Medicaid management fees

- $2.50 PPPM, reduced from $5.00 upon ACA Primary Care enhanced payments 2013-2014.
## Value based payments

### Medicare programs
- **PQRS:** 1% bonus, transitioned to 2% penalty 2015 - 17
- **MU:** cash payments based on EHR implementation and use of functionality, transitioned to 1 - 3% penalty 2015 - 2017
- **E-Rx bonuses:** 2% 2009, transitioned to penalty 2014
- **Coming:**
  - Value based modifier (VBM): for groups >100 in 2015, increase or decrease FFS payments based on quality and cost data from 2 years prior.

### Commercial contracting
- **Pay for Performance**
- **FFS Withhold returned based on clinical quality outcomes**
Value based payments

Accountable Care Organization Experience

- shared savings based on total cost of care, adjusted for quality
- No up-front funding
- Must hope for pay for infrastructure before revenue for better or lower cost care
- No payment for even the highest quality of care if no overall savings beyond target

- MSSP: benchmark and attribution issues caused MSSP to fail most places, including ACCGM
- VT Commercial ACO: first year rate setting, exchange population, poor attribution / enrollment process and FFS rates widely variable
Accountable Care Coalition of the Green Mountains
ACO experience

• Medicare Shared Savings Program
  o Difficult for already low cost networks to benefit, as targets based on your low utilization and cost history.
  o Very expensive to start
  o Many measures to report
  o Down side risk third year.
  o For practices: Opt out process, meetings, mandated trainings, reporting on measures, different care processes for Medicare patients
Value based payment programs
Reasonable goals?

Pay good doctors and practice teams fairly and expect that they will do good work.

Stable, meaningful, limited measures to assess the work of good doctors

Timely reporting from plans, payers, programs

Reward practices that perform well

Reduce the administrative hassles and paperwork requirements of documentation.
Dedicating increasing amounts of income and personal time to lead and manage quality programs is not sustainable.

Mark M. Nunlist, MD, MS, Sean Uiterwyk, MD, and Betsy Nicoletti, MS, CPC
Planning for the Future – very costly now

“Ultimately, improvements at our practice are financed primarily by physician salaries and investments of personal time. The revenue streams necessary to support ongoing investment in systems, staff, and care processes are variable and inconsistent, leaving the physicians to fund these services themselves. So far, the physicians have trusted in the future, but that trust cannot last.”

“Physicians cannot keep trying to “do the right thing” (without) money ... to support operations.”

“The status quo is untenable.”

_Fam Practice Management_. 2014 Sep-Oct;21(5):6. Mark M. Nunlist, MD, MS, Sean Uiterwyk, MD, and Betsy Nicoletti, MS, CPC
Documentation overload
The paradox of value-based payment programs

• Having an accessible primary care physician is the best predictor of quality health care.

• Every minute of excess documentation, data gathering and reporting diverts from care, and distracts from some of the important aspects of history, exam or thinking about the critical patient care items.
Practice Transformation for value based payment programs

• Most effective when applied to all patients
  o Care management
    ▪ Prevention
    ▪ Chronic diseases
  o Focus on key quality metrics
• Use EHR data rather than reliance on “old” data from payers or programs.

• Payment must be meaningful enough to support changes and new service resources
• Outcome / performance data most effective if applied to our practice, our patients
Selecting measures for prioritization at Evergreen Family Health

• Help us to take better care of patients

• Help us to be paid adequately, so that we can take better care of patients
  ○ Direct pay for quality
  ○ Possible shared savings

• We have some control over

• NOTE: Measures seem to change frequently, so gearing up the care process to address measures that may be abandoned is a waste of valuable resources.
Last Thoughts

Transition to value based programs brings unintended consequences

- Documentation overload can be the result of attempts to assess quality / value
- Failure to recognize the costs of transitions to new models of care delivery can weaken the delivery system
- Any new system will create new adverse incentives

Value based payment systems are inherently costly to administer

Our office EHRs should have the data necessary to monitor practice quality metrics to support quality programs
### Achievements

- Transitioned to provide comprehensive primary care services in a medical home model
- Created a high performing primary care network
- Learned that traditional ACO models do not work for high performing network
- Pay for performance contracts are successful for high quality network

### Challenges

- Documentation to demonstrate quality / value detracts from caring for patients
- Expecting high performance systems to prove quality without paying them adequately will weaken them
- Potential rewards for quality must be local, achievable, and substantial to be meaningful
Transitioning from Fee-for-Service to Outcomes Based Payments

Toby Sadkin, MD
St. Albans Primary Care
Chair, Primary Care Health Partners
The Connected Clinician: Challenges and Achievements
Transitioning from Fee for Service to Outcomes Based Payments

Fee for Service ➔ Pay for Performance

Moving to

Toby Sadkin, MD
St. Albans Primary Care
Chair, Primary Care Health Partners
The largest physician-owned primary care group in Vermont

- 26 physicians
- 10 NP’s
- 4 PA’s
- 37,000 active patients

<table>
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<th>Pediatrics</th>
<th>Internal Medicine</th>
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Primary Care Health Partners (PCHP)

Our Mission

We are a group of physician-owned, independent primary care practices. Through our patient centered medical home model*, we work collaboratively to provide compassionate, accessible, high quality healthcare. We believe that through this work we can enhance the well-being of our patients, and the quality of health in our communities.

*Patient-centered medical home model—a model for primary care which provides a team based approach to comprehensive, coordinated, accessible care with accountability for quality and safety and with a focus on education and self-management tools to help patients take an active role in their health and well-being.
Our Vision

Primary Care Health Partners will remain an independent physician-owned model for integrated quality health care. We will strive to remain adaptable, resilient and fiscally responsible. We will stay at the forefront of primary care using an evidence-based approach and embrace quality improvement tools and new technologies. As healthcare evolves, we will continue to advocate for independent primary care at local, state, and national levels.
Our Core Values

- Patient and family-centered care
  - Compassion
  - Collaboration
  - Prevention
  - Wellness
- Cost effective quality care
- Health education and advocacy
- Promote Care using Technology
Primary Care Health Partners

Templates, Workflows, and Algorithms......oh my!

Meaningful Use

NCQA

ACO Measures

Blueprint
Track 3: The Connected Clinician: Challenges and Achievements
Meeting the Measures

- Workflows have been put into place to help us meet the quality measures

- Special templates and screening tools have been added to our noteforms to help us with documentation in a format that is measurable and reportable
PCHP Fall Screening Workflow

1. **Falls Screening**
   - Yes: **Is Patient 65+?**
     - Yes: Use standardized falls risk screening/assessment – ask about a HX of falls
     - No: No Screening necessary
   - No: No Screening necessary

Consider a referral to PT
PCHP Blood Pressure Screening and Follow Up

1. Screening for High BP and F/U
   - BP is \( \leq 120 \) and \( < 80 \)
     - Yes: No F/U needed
     - No: BP is between 120-139 or 80-89

2. BP is between 120-139 or 80-89
   - Yes: Schedule f/u apt w/in 1 yr, Order educational material on lifestyle modification, OR referral to CHT or dietician
   - No: B/P >= 140 or >= 90

3. B/P >= 140 or >= 90
   - Yes: Schedule f/u apt w/in 4 wks, AND order educational material on lifestyle modification or referral to CHT or dietician
   - No: F/U B/P is >= 140 OR >= 90

4. F/U B/P is >= 140 OR >= 90
   - Yes: Order educational material on lifestyle modification AND 1 or more of the following: Anti-hypertensive pharmacologic therapy, lab tests, Electrocardiogram or referral to CHT or dietician
   - No: Schedule f/u apt w/in 1 yr
PCHP Chlamydia Screening Workflow

1. **Chlamydia Screening**
   - Age 16-24
   - Yes: Obtain Urine sample
   - No: End

2. **Obtain Urine sample**
   - Yes: Sexually Active
   - No: End

3. **Sexually Active**
   - Yes: Counsel: Chlamydia Screening
   - No: Document reason why

4. **Counsel: Chlamydia Screening**
   - No: Negative/End
   - Yes: Result

5. **Result**
   - No: Negative/End
   - Yes: Positive/Treat as indicated
### PCHP Screening Template for Note

#### (PCHP) Screening (Comprehensive)

**All Patients**

- **YN** Seen by Outside Provider Since Last Visit?
- **YN** If seen by outside provider did patient self-refer?

**12+ years**

- **☐** Tobacco Use Screening Performed
- **YN** Current Smoker
- **☐** Smoking Cessation Encouraged
- **☐** Adolescent Depression Screening Performed
- **☐** Adult Depression Screening Performed

**Psychiatric State Evaluation Completed**
- **☐** Adolescent patient refused screening
- **☐** Adult patient refused screening

**66+ years**

- **☐** Falls screening performed
- **☐** Patient Not Ambulatory (exempt from screening)

#### Bipolar Disorder/ Major Depressive Disorder

**18+ years**

- **☐** Alcohol Consumption Screening
- **☐** Assessment of Substance Use

#### Dementia

- **☐** MMSE (Score ___)
- **☐** SLUMS (Score ___)
- **☐** IQCODE (Score ___)
- **☐** AD8 (Score ___)
- **☐** MoCA (Score ___)
- **☐** BOMC (Score ___)
- **☐** Patient refused screening
- **☐** Diagnosed Severe Dementia
- **☐** Receiving Palliative Care

#### Major Depressive Disorder OR Dysthymia

**18+ years**

- **☐** PHQ-9 Completed (Score ___)
- **☐** Receiving Palliative Care
### Screening Flow Sheet

**Primary Care Health Partners**

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<td>Anticipatory Guidance: Preventing Falls</td>
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<td>BMI CALCULATED</td>
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<td>CHLAMYDIA RESULT</td>
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<td>SMOKER STATUS</td>
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<td>Visit For: Single Organ System Diabetic Foot Exam</td>
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<td>Positive</td>
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<td>Retinal or Dilated Eye Exam Performed</td>
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<td>Echo I Ventricle Ejection Fraction</td>
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PCHP Pilot ER Follow Up Algorithm

- Goal to reduce ER Utilization

- When ER or Urgent Care report is received, each patient is contacted by a nurse
  - How are they doing?
  - Do they need anything or have any questions?
  - Do they need/want a follow up office visit?
  - Chance to educate on office hours, same day visits

- Designed a note template for ER follow up, including identifying barriers to office visit instead of ER visit

- Results pending (will soon see if we are impacting ER Utilization)

- We found the patients really appreciate the follow up calls!
PCHP ER follow up visit template excerpt

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<th>選項</th>
<th>事件描述</th>
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<tr>
<td>YN</td>
<td>Mental Health/Behavioral Health/Crisis Intervention</td>
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<td>YN</td>
<td>Acute Alcohol Intoxication</td>
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<td>YN</td>
<td>A Cardiac Problem</td>
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<tr>
<td>YN</td>
<td>Drug Overdose</td>
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<tr>
<td>YN</td>
<td>Gastrointestinal Problem</td>
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<tr>
<td>YN</td>
<td>Orthopedic Problem</td>
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<tr>
<td>YN</td>
<td>Pulmonary Problem</td>
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<tr>
<td>YN</td>
<td>Urological Problem</td>
</tr>
<tr>
<td>YN</td>
<td>Back Problem</td>
</tr>
<tr>
<td>YN</td>
<td>Headache Problem</td>
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<tr>
<td>YN</td>
<td>OB/GYN Problem</td>
</tr>
<tr>
<td>YN</td>
<td>Dental Problem</td>
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Other or more specific Reason:

Brief summary of ER visit and outcome
Dr.'s Office was open at the time of ER or Urgent Care visit.
Patient contacted office prior to being evaluated in ER or Urgent Care.
A same day/next day office appointment was offered.
Patient accepted appointment / declined same day or next day appointment.
Patient was no show for same day/next day appointment.
Patient was referred to emergency room or urgent care by the office.
Transportation issues as they relate to reasons patient sought care elsewhere.
Patient experienced transportation issues related to travel to Dr.'s office.
Patient experienced transportation issues related to travel to ER.
Method of Transport (Private Vehicle, Ambulance, or Taxi)
Pt. reason for ER/Urgent care visit could potentially have been managed with office visit.
Office hours, after hours contact, and same day appointment policy reviewed with patient.
Telemedicine in Vermont

Jaspinder Sra M.B., B.S.
Director - Rapid Response Team, UVM MC
Assistant Professor – UVM COM
Attending – Internal Medicine Hospitalist, UVMMC
Medical Informaticist – UVM MC
ACO – ONE CARE

- Health Catalyst
- Population Health Care Model
UNLOCK
  - integrate, catalogue, and secure

PRIORITIZE
  - show the biggest opportunities.

DISCOVER
  - discover the right patient populations.

IGNITE CHANGE
  - assemble a team to select high priority projects within a selected area or patient population
**Population Health Care Model**

**Healthy/Well Majority**
- **Team**: Primary care medical home with practice level support
- **Interventions**: Wellness screening (visit, survey), panel and quality mgmt., preventive care, incentive programs, automated interaction (apps, virtual visits, pt. portals), shared decision making, and managing of single episode events (e.g., transitions of care)
- **Focus**: Conveniency, low cost interactions for simple/self-limiting illness

**Early on set stable chronic illness**
- **Team**: Primary care medical home with specialty consultation and return to PCP
- **Interventions**: Healthy living workshops, defined referral to specialist, short term interventional services + all category 1
- **Focus**: Optimal management of chronic disease, prevent progression and complications; self management & education

**Complex/High Cost Acute Catastrophic**
- **Team**: Patient Centered Medical Home and ongoing specialty center care and/or centers of excellence
- **Interventions**: Palliative care, specialty/tertiary management, intensive home intervention + select category 3
- **Focus**: Manage complications, avoid hospitalization and other rescue care, palliative care and end of life discussions

**Full onset chronic illness & rising risk**
- **Team**: Patient Centered Medical Home with ongoing specialty and community care (“Medical Neighborhood”)
- **Interventions**: Single point of care coordinator contact, full continuum integration, shared care planning + majority of category 2
- **Focus**: Category 2 plus Care coordination, social support and family support

**Primary Care Medical Home Attributes:**
- Access
- Continuity
- Coordination
- Holistic
- Performance driven
- Technology enabled

**Patient Centered Medical Home Care Physician / Advanced Practice Provider Support Team:**
1. Health Coaches
2. Medical Assistants
3. Triage Nurse
4. Nurse Care coordinator/Nurse educator
5. Social Worker
6. Registry manager
7. Community Health Team (e.g., dietician, pharmacist, MH/SA clinician, etc.)

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**Track 3: The Connected Clinician: Challenges and Achievements**
Zooming in on UVM Health Network Level
The UVM Health Network

UVM MC
Same EMR
Patient Centered Medical Home
Health Risk Appraisal
Geo-mapping
Optimal patient at optimal time at optimal facility
Health Risk Appraisal
TeleMedicine
Virtual Visits
Web based questionnaire
The UVM Health Network

- Health Risk Appraisal
- Web Based Qn-aiire
- Virtual Visits
- EMR
- Pt Centered Med Home

UVM Health Network

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<th>UVM MC</th>
<th>CVPH</th>
<th>CVMC</th>
<th>ECH</th>
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<td>Optimal Patient</td>
<td>Time</td>
<td>Place</td>
<td>Service (MD)</td>
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- Shared EMR
- Telemedicine
- Standardized TOC

Geo-Mapping
Hot Spotting by ZIP

ID High Utilizers by ICD
## Examples

### Total Joint Discharge Destination

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<th>Clinic Name</th>
<th>Surgery Count</th>
<th>SNF</th>
<th>HH/Home</th>
<th>IP Rehab</th>
<th>Short Term Hospital</th>
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<td>UNIVERSITY OF VERMONT MEDICAL CENTER</td>
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EXAMPLES

Chronic Pain Syndrome beneficiaries
Utilization per 1000 beneficiaries

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<th>Utilization Per 1000 Beneficiaries</th>
<th>Population without Chronic Pain Syndrome</th>
<th>Population with Chronic Pain Syndrome</th>
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<td>Specialist</td>
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<tr>
<td>Orthopedic</td>
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<td>Other</td>
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THANK YOU