INTRODUCTION
The United States healthcare system is at a tipping point.

Chronic disease is the most significant driver of healthcare costs in the nation, representing an estimated 85 percent of our annual spend.¹ As patients bear a higher share of the expenses and both private and public payers react to rapid changes in our clinical and demographic profile, there is tremendous pressure to shift from a volume- to value-based payment system.

Rather than a fee-for-service market in which physicians are compensated based on the number of services they perform, the industry is moving toward preventive medicine with compensation based on outcomes. But in a system as large and complex as the U.S. healthcare industry, how can we begin to slowly turn the ship to put it on this new course? How can providers, payers and consumers alike thrive in this new environment?

The Institute for Healthcare Improvement (IHI) has laid out an approach to optimize the healthcare system deemed the “Triple Aim.”² The IHI believes we must simultaneously pursue three dimensions: improving the patient’s experience of care, improving the health of populations, and reducing per capita costs. To promote the triple aim, payers are pushing forward “value-based” reimbursement based on the quality of care. To properly take advantage of these value-based programs, practices must begin to engage in population health management. This transformation requires not only a change in philosophical view, but significant investments in new organizational, workflow, and IT processes.

If you are a physician or healthcare organization considering participation in one or more value-based programs, this guide aims to help you navigate the transition by answering two fundamental questions:

1) What are the current value-based arrangements, and how am I measured and paid within each?

2) How can I focus my practice on population health management to maximize reimbursement under these arrangements?

In addition to answering these questions, this guide will introduce you to Greenway Community, a population health management tool including analytic, risk stratification, care management, and data exchange solutions that enable providers to make more informed decisions and deliver more efficient, effective care.

Three icons will be used next to section takeaways, indicating the target readership for that particular bullet.

- Providers
- Care Managers
- IT Analysts

¹[www.cdc.gov/chronicdisease](www.cdc.gov/chronicdisease)
²[www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx](www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx)
# TABLE OF CONTENTS

Introduction................................................................................................................................. 2

How We Got Here .................................................................................................................... 6
  An Aging Population ............................................................................................................. 7
  Value-based Contracts ........................................................................................................... 7
  Getting Involved .................................................................................................................... 8

Value-based Programs ............................................................................................................. 10
  The Medicare Value-based Modifier ....................................................................................... 11
    Overview ............................................................................................................................. 11
    Getting Paid ....................................................................................................................... 11
    Performance and Measures ................................................................................................. 12
  The Accountable Care Organization ....................................................................................... 13
    Overview ............................................................................................................................. 13
    Getting Paid ....................................................................................................................... 14
    Performance and Measures ................................................................................................. 14
  The Patient-Centered Medical Home ..................................................................................... 15
    Overview ............................................................................................................................. 15
    Getting Paid ....................................................................................................................... 16
    Processes and Measures ...................................................................................................... 16
  The Chronic Care Management Fee ...................................................................................... 17
    Overview ............................................................................................................................. 17
    Getting Paid ....................................................................................................................... 17
    Prerequisites ....................................................................................................................... 17

Medicare Advantage and Risk Adjustments ............................................................................. 18
  Overview ............................................................................................................................. 18
  Getting Paid ....................................................................................................................... 18

Hierarchical Condition Categories ............................................................................................ 19

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ................................ 19
  Overview ............................................................................................................................. 19
  Getting Paid ....................................................................................................................... 20
  Processes and Measures ...................................................................................................... 20

Managing Population Health .................................................................................................. 22
  Introduction to Population Health .......................................................................................... 23
  Preparing the Organization ...................................................................................................... 23
  Leadership ............................................................................................................................. 23
  Total Buy-in .......................................................................................................................... 24
  Staff Preparation ................................................................................................................... 24
  Network Evaluation .............................................................................................................. 25
  Spreading the News .............................................................................................................. 27
  Technology ............................................................................................................................ 27
  Getting the Complete Picture ............................................................................................... 27
  Risk Stratification .................................................................................................................. 28
  Reporting ............................................................................................................................... 28

Care Coordination and Patient Engagement ........................................................................... 29
  Care Coordination Overview ............................................................................................... 30
  Transitions of Care ............................................................................................................... 31
  Patient Education .................................................................................................................. 31

Process Changes ..................................................................................................................... 32
  Workflow .............................................................................................................................. 32
  Same-day Access .................................................................................................................. 33
  The Comprehensive Care Visit .............................................................................................. 34
  Shared Decision-making ....................................................................................................... 34
  Collaborative Care Meetings ................................................................................................. 35
  Measuring Success ............................................................................................................... 35

The Greenway Community Advantage .................................................................................... 38

Useful Charts and Measures .................................................................................................... 40
  ACO Measures ...................................................................................................................... 41
  Administrative Claims Process Measures ............................................................................. 42
  Administrative Claims Outcomes Measures ......................................................................... 43
HOW WE GOT HERE
HOW WE GOT HERE

An Aging Population
The fee-for-service environment has dominated the U.S. healthcare market since the emergence of private insurance and Medicare. However, backlash to rapidly rising costs mean deep reform is not only coming, it is well underway.

Value-based payment models seek to remedy the situation through a variety of incentives and structures. Overall, the goal is to encourage preventive medicine and refocus treatment from the acute environment to the ambulatory one, where costs are much lower and more controlled.

Value-based Contracts
An aging population suffering from a multitude of unmanaged chronic conditions has payers operating within an unsustainable system. With the Centers for Medicare & Medicaid Services (CMS) leading the way, payers are seeking to compensate physicians based on the quality of care provided, or what we’ll call patient outcomes, rather than the number of services rendered.

Payers now offer multiple value-based models and are increasingly reducing the amount they pay per service by two–three percent, depending on the specialty. When considering the thin margins of many practices, this cut can make or break profitability.

Payers offset the reduction with quality-based compensation programs that take many forms. Providers may receive a positive or negative adjustment — penalties or incentive payments — such as the value-based modifier, based on care quality. Payers might offer a pure capitated model, where a practice is responsible for the health of a whole population. Or it might involve a blended payment, in which providers can earn fee-for-service payments and a care coordination fee per patient. We’ll detail these compensation models, including how you can participate and maximize payment in the Value-based Program section.

Takeaways

• An aging population and prevalence of chronic conditions are pushing the U.S. healthcare system to its brink with unsustainable costs

• Value-based programs that tie physician reimbursement to overall health expenditures and quality are the payer’s remedy

Providers
• These programs also represent a significant financial opportunity, with the Chronic Care Management Fee opening a $200,000–$300,000 opportunity per provider per year
Getting Involved

As we reach the inevitable tipping point, practices and providers have an opportunity to opt in and get ahead of the curve. Beyond deeper engagement with patients, value-based programs offer a significant financial benefit, with the opportunity to make $200,000 to $300,000 more per provider per year in just one specific program, the Chronic Care Management Fee. Managed effectively, these programs can be particularly attractive to primary and ambulatory care providers who deal with preventable chronic diseases on a daily basis.

The most-billed-for conditions in the ambulatory space are diabetes, cardiovascular disease, chronic obstructive pulmonary disease (COPD), obesity, and arthritis, among others. The common theme? They are all preventable, and the targets of value-based programs. You can make an impact on the cost of healthcare and help build a smarter healthcare system by improving patient outcomes; and if you implement the right processes, practices, and technology, you can improve your bottom line as well.
Our national healthcare crisis is strongly related to our aging population.

Every 8 seconds a Boomer enters Medicare

These patients are...

- 65+
- More likely to present chronic diseases

Which represent a disproportionate healthcare expenditure due to...

- 45% Are noncompliant with their care plans

Largely because of unmanaged conditions like... 

- 20% responsible for 85% healthcare costs
- Diabetes
- Obesity
- Cardiovascular disease

Leading to hospitalizations

Average hospitalization cost: $10,000

In many cases cost could be avoided with better ongoing care.

Clearly this system is not sustainable for providers, patients or payers.
VALUE-BASED PROGRAMS

Now that you know why the healthcare industry is shifting to a value-based system, let’s review five value-based programs in which you may wish to participate. We will examine both public and private contracts, including the overall program structure, how physicians are compensated and how each program measures and tracks performance. Later we will examine the best practices and processes an organization should implement to maximize the opportunities presented by each of these programs and their derivatives.

Specifically, we address the following:

- The Medicare Value-based Modifier
- Accountable Care Organizations (ACOs)
- Patient-Centered Medical Homes
- The Chronic Care Management Fee
- Medicare Advantage

As you are considering your options, it is important to note that most practices are likely to participate in more than one value-based program due to overlapping measures and that most value-based plans still have fee-for-service components. Let’s dive in.

The Medicare Value-based Modifier

OVERVIEW

The Medicare Value-based Modifier is important because it will apply to all physicians by 2017. The modifier applies a positive or negative compensation adjustment in traditional Medicare plans based on quality. In other words, practices receive incentive payments or pay a penalty on their Medicare reimbursement depending on the health outcomes they help patients achieve.

CMS is gradually phasing the program in, so the practices to which the value-based modifier applies depends on the practice size and calendar year. In 2013, it applied to practices with 100 physicians or more. In 2016, it will apply to those with 10 or more physicians. By 2017, the Affordable Care Act mandates that it apply to all practices with one important caveat: the value-based modifier does not apply to participants in the Medicare Shared Savings Programs (MSSP), an ACO model discussed below, or the Pioneer ACO model.

GETTING PAID

The positive or negative adjustment of the value-based modifier is generally tied to the Physician Quality Reporting System (PQRS). PQRS is an incentive program that pays providers to report on a set of quality measures. Physicians can use the data to see how they perform against their peers and to ensure patients get the right care at the right time.

2015 REQUIREMENTS

If you have a practice with 100 or more physicians in 2015, you are generally required to report on a select group of PQRS measures based on your practice’s distinct competencies. You can report in one of two ways: register for the PQRS Group Practice Reporting Option (GPRO) and report measures through the GPRO Web Interface or a registry, or elect to use CMS’ administrative claims option. A practice that chooses not to participate automatically faces a one percent negative adjustment.

If you register for PQRS GPRO, you can also elect to participate in quality tiering reporting, which subjects practices to an additional positive, negative or neutral adjustment. Quality tiering benchmarks your performance against other providers and adjusts your Medicare reimbursement based on how your quality of care compares.

2016 REQUIREMENTS

In 2016, practices with 10 or more physicians must participate in the value-based modifier program or face a two percent negative adjustment to all Medicare payments. Quality tiering reporting is also mandatory and can result in a positive, negative, or neutral adjustment for practices with more than 100 providers or in a neutral or positive adjustment for smaller practices.

2017 REQUIREMENTS

By 2017, the value-based modifier requires all practices to participate in PQRS, regardless of size, or incur a two percent negative adjustment.
The quality tiering adjustment continues to be mandatory and is based on cost and quality measures set according to industry performance benchmarks. Practices with fewer than 10 providers may receive a positive or neutral adjustment and practices with 10 or more providers face strict requirements that can result in a positive, neutral, or negative adjustment. The table below outlines the adjustments you can expect to receive based on your practice size as well as your cost and quality performance.

| CY 2017 VM Payment Adjustment Amounts for Groups with 2-9 Eligible Professionals and Solo Practitioners |
|----------------------------------|----------------------------------|----------------------------------|
|                                  | LOW QUALITY                       | AVERAGE QUALITY                   | HIGH QUALITY                     |
| LOW COST                         | 0.0%                             | +1.0x*                           | +2.0x*                           |
| AVERAGE COST                     | 0.0%                             | 0.0%                             | +1.0x*                           |
| HIGH COST                        | 0.0%                             | 0.0%                             | 0.0%                             |

| CY 2017 VM Payment Adjustment Amounts for Groups with 10 or More Eligible Professionals |
|----------------------------------|----------------------------------|----------------------------------|
|                                  | LOW QUALITY                       | AVERAGE QUALITY                   | HIGH QUALITY                     |
| LOW COST                         | 0.0%                             | +2.0x*                           | +4.0x*                           |
| AVERAGE COST                     | -2.0%                            | 0.0%                             | +2.0x*                           |
| HIGH COST                        | -4.0%                            | -2.0%                            | 0.0%                             |

Notes
- "X" refers to a payment adjustment factor yet to be determined
- * higher performing groups serving high-risk beneficiaries (based on average risk scores) are eligible for an additional adjustment of +1.0x%

Note: Includes Medicare Part A & B for inpatient and outpatient care, but not Part D for drug expenses. Payment is standardized to exclude geographic payment differences.

**PERFORMANCE AND MEASURES**

To determine whether a positive, negative or neutral adjustment is applied, the Medicare value-based modifier looks at both cost and PQRS measures established by benchmarking providers against one another.

The cost measures focus on the total per capita costs of the leading causes of death, and therefore the leading healthcare cost drivers, in the U.S. Measurements include the per capita cost of COPD, heart failure, coronary artery disease and diabetes. A provider’s per capita costs for these conditions are measured against other practices and assigned to one of three tiers: low, medium or high.

If quality tiering relied only on cost, it would create a backward incentive structure in which physicians were encouraged to reduce costs without taking quality of patient care into consideration. To prevent a potential decline in care, PQRS standards hold practices accountable for their quality performance, also based on industry benchmarks and assigned to low, medium or high tiers.

Tracking performance against these measures is no simple task. Many are composite scores, meaning one score may have multiple, variable measures, such as the “Chronic Conditions Composite.” This specific measure looks at four diabetes indicators, COPD and heart failure, all in one composite score. Ultimately, the denominator represents a relevant population, and the numerator represents the number of patients that count toward a positive valuation.

For example, measure 40, “Osteoporosis: Management Following Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older,” measures the number of patients who have fractured these bones as the denominator, and those who received the appropriate ICD-9 codes as the numerator. Tracking this highly specific information manually is difficult. Comparing it to the benchmark and tracking performance against that benchmark is even harder. To successfully maximize revenue under the Medicare Value-based Modifier model, providers must integrate quality reporting and monitoring costs into their daily workflow.
If a provider chooses not to participate in PQRS GPRO, they must use CMS’ administrative claims option to report. With this reporting option, there are 14 measures that track screenings for certain diseases, such as breast cancer screenings for women and A1C tests for patients over 75. The quality tiering election is subject to a different set of 10 measures, which largely track hospital discharges for conditions like diabetes, heart failure and COPD. The denominators for each measure cover a different population of patients, sometimes very specific ones, which can create significant reporting barriers.

GREENWAY COMMUNITY ADVANTAGE
The Medicare value-based modifier will be mandatory by 2017; however, its measures can be difficult to track and benchmark. Greenway Community allows you to view quality measures and cost performance at each level of the enterprise: the organizational level, practice level, provider level and even patient level. The tool shows the factors causing quality and cost underperformance and how to make improvements.

The Accountable Care Organization

OVERVIEW
An Accountable Care Organization (ACO) is an alliance between a group of providers that seeks to improve care, increase the health of populations and reduce costs. To accomplish this goal, ACOS focus on reducing medical errors and eliminating duplicative services. An ACO may include hospitals, ambulatory providers and other healthcare organizations all working together to ensure a patient receives the right care at the right time.

The ACO was introduced by the Affordable Care Act as a measure to serve the triple aim. However, the policy initiative recognized that success was contingent upon providers’ ability to share in the savings offered by collaboration and preventive care. CMS initiated three programs to give provider organization alliances of 5,000 or more patients the opportunity to share in the savings:

- The Medicare Shared Savings Program (MSSP), in which 99 percent of all CMS ACOs participate
- The Advanced Payment ACO
- The Pioneer ACO

Beyond these CMS ACO models, the private payer market also offers ACO contracts to provider networks.

Takeaways

Care Managers
- Quality reporting will apply to all provider organizations that accept Medicare by 2017, which subjects organizations with 10 or more providers to penalties as well as incentives
- The Medicare Value-based Modifier ties cost and quality to reimbursement

IT Analysts
- Alignment with PQRS measures, especially composite measures, can be difficult to track
GETTING PAID

Under the MSSP, ACO providers are paid according to three distinct elements.

1) **ACOs still receive fees for service**, although the ultimate goal is to offer fewer services through preventive care.
2) **Providers earn a share of the savings generated by reduced overall costs to CMS.**
3) **Sharing in these savings is adjusted based on the quality of care performed.** This third element ensures providers are not incentivized for activities like cutting back on necessary facilities or personnel to reduce costs.

If an organization provides a high level of care and reduces costs, it can generally receive up to 50 percent of the savings generated. ACOs begin sharing in these savings on the first dollar after a minimum savings rate is achieved. CMS establishes this rate based on average nationwide and local costs, and savings are realized once expenditures drop below the benchmark.

The second CMS ACO model, **Advanced Payment ACOs**, provides upfront funding to physician networks that lack the capital necessary to transition to a traditional MSSP ACO. Participants receive an advance of $250,000, a $36 per beneficiary upfront variable payment, and an $8 per beneficiary monthly payment. However, these advance payments must be repaid. If the ACO does not create enough savings to repay the loan halfway through its second year, CMS recoups those payments from the earned savings in the subsequent year. CMS may recoup all payments from an ACO that does not complete its contract.

Lastly, the Pioneer ACO Model is designed for healthcare organizations and providers that already have experience coordinating care for patients. The model enables these provider groups to move quickly from a shared savings payment model to a population-based payment model on a track consistent with, but separate from, the MSSP.

PERFORMANCE AND MEASURES

Regardless of program, the ACO model awards organizations based on a combination of cost savings and quality of care. **An ACO’s care quality is determined by points earned against 33 measures within four domains aligned with CMS’ PQRS and electronic health record (EHR) incentive programs.**

These four domains include:
- Patient experience of care (seven measures)
- Care coordination and patient safety (six measures)
- Preventative health (eight measures)
- At-risk population management (12 measures across five chronic diseases)

Because transforming into an ACO requires significant time and resources, CMS does not implement the quality adjustment immediately. In the first year, an ACO is paid merely for reporting on all 33 quality measures. Year two moves beyond reporting to a pay-for-performance model, where the practice reports on and is measured against benchmarks for 25 of the 33 measures. Finally, in year three, this reporting requirement and pay-for-performance model applies to all of the measures. A full list of measures is found in the appendix.

CMS establishes national benchmarks based on comparative data and awards points according to ACOs’ attainment level for each measure. **To be eligible to share in the savings generated, ACOs must meet cost savings criteria and cross a minimum attainment level of 30 percent** — at or above the 30th percentile of performance data — on at least one measure in each of the four domains.

While the ACO model can be highly profitable, the measurement requirements present certain challenges that must be considered before entering into this type of agreement.

- Benchmarking and tracking against some measures can be difficult. For example, both the diabetes and coronary artery disease composite measures within the at-risk population domain are pass-fail. While a practice only needs to pass the threshold set by CMS for the composite as a whole to pass the measure, each composite has several individual measures.
- The domains themselves can also be difficult to manage. Within the patient and caregiver experience domain, many of the measures are based on patient surveys rating access to specialists, patient education, shared decision-making and functional status. While the survey issued is well regarded, it is subjective and requires a high response rate to be accepted.
- Lastly, the measures themselves are complicated. More than 15 unique denominators are present, each tracking a different patient type. For example, within the fall-risk measure, three different numerators...
apply depending on which of the two patient types, patients over 65 or patients over 65 with a history of falls, is selected. Organizations without sophisticated reporting tools may find it difficult to address every required nuance.

GREENWAY COMMUNITY ADVANTAGE
Greenway Community gives your organization visualized and actionable insight into quality and cost performance at each level of the ACO. With this view, providers can maximize their share of captured savings by reacting to factors causing underperformance. Patients who are hindering quality performance because of their health or noncompliance can be easily identified and managed using Greenway Community Manager for follow-up.

“Since becoming an ACO and participating in value-based programs, we’ve seen our revenue increase across all of our contracts and payers by 10 percent. We defied negative expectations.”

—Edward Gold, M.D.
Board Certified in Internal Medicine and Oncology & Hematology
Chief Operating Officer, Old Hook Medical Associates

The Patient-Centered Medical Home

OVERVIEW
The patient-centered medical home (PCMH) is designed to transform how care is delivered. This model focuses on care coordination and patient engagement to turn primary care into something desirable to patients with increased quality, lower costs and improved experience of care. To become a PCMH, a provider organization could be recognized by the National Clinical Quality Association (NCQA). The process-oriented accreditation can take up to 18 months to complete and includes:

- Filing an application
- Standards and guidelines training
- Applying those standards and guidelines to reform the practice
- Software training
- Purchasing a survey tool
- Evaluation by the NCQA

While the transformation to a PCMH can be challenging due to its scope, it opens substantial opportunities to providers and a unique care delivery model to patients.

Takeaways

Care Managers
- ACOs are networks of provider organizations that seek to provide coordinated, high-quality care while controlling costs

Providers
- Physicians in ACOs are reimbursed through fees for service and sharing in savings to the healthcare system

IT Analysts
- 33 quality measures across four domains:
  - Patient experience and satisfaction
  - Care coordination and patient safety
  - At-risk population
  - Preventative health
GETTING PAID

A PCMH is not compensated by CMS, so its distinct advantage is an open door to private payers and participation in state initiatives. The program’s overall structure allows practices to participate in multiple programs successfully—such as CMS ACOs, meaningful use, the value-based modifier, and other overlapping programs—enabling the organization to capture significant revenue.

Each PCMH program is different across states, initiatives and payers, and payment structures vary tremendously. However, they all follow certain general recognition standards. While they generally maintain the ability to charge a fee for services, the following payment incentives have been observed in different states:

- A set care coordination fee
- Compensation for electronic visits
- Cost savings
- A percent increase in fees for service
- A per patient per month fee, ranging from $1.50-$24.00

PROCESSES AND MEASURES

Becoming a PCMH involves meeting six separate process goals, consisting of:

- The patient-centered access standard, which aims to provide healthcare consumers access to appointments and team-based care 24/7, whether in person, remotely, on the phone or online.
- The team-based care standard, which measures approaches suited to a population culturally, linguistically and in a team-based way. This standard seeks to improve continuity of care by assigning personal clinicians to patients and families, and must also provide access to evidence-based patient education materials, equal access to care and record transfers.
- The population health management standard, which provides evidence-based support to patients to manage population health. The standard requires PCMHs to collect demographic information, use EHR systems and track risk factors such as body mass index (BMI), allergies and blood pressure. To promote preventive care, comprehensive health assessments are required and practices must use data to stage proactive care interventions.
- The care management and support standard guides practices in identifying patients who need care management, referrals, collaboration and medication management. The practice must also encourage self-care at home and work.
- The care coordination standard focuses on the provider’s tracking and follow-up with patients. This entails tracking lab tests, flagging abnormal results and notifying patients in a timely manner.
Practices must also track and follow up with referrals. Finally, the practice must coordinate care transitions by sharing information with hospitals and contacting family members, as well as obtaining discharge summaries.

- The performance measurement and quality improvement standard requires practices to measure quality performance, costs and resource use, then identify gaps and institute needed improvements.

All of these process improvements require documentation and detailed reporting. However, while becoming a PCMH may appear to be an arduous process, the benefits to patients and providers are abundant.

### The Chronic Care Management Fee

#### OVERVIEW

Traditionally, payers have regarded the out-of-office tasks to help a patient manage his or her chronic condition as bundled into the fee-for-service model. Payers expected providers to perform these tasks regardless of incentives. With the chronic care management fee (CCM), CMS now enables practices to charge for care that is not conducted face-to-face, but plays a significant role in helping a patient manage their care. However, to be able to bill for the CCM, a practice must meet certain proactive care management prerequisites.

### GETTING PAID

Qualified providers, including certain mid-level providers, can bill up to 20 minutes of qualifying care per patient per month for the CCM. In return, the practice receives more than $40.00 per patient receiving such care per month.

Permitted care includes medication reconciliation, overseeing a patient’s self-management of medication, ensuring the beneficiary gets recommended preventive services and actively monitoring the patient’s condition. The overarching purpose of these procedures is to encourage patients and providers to actively manage chronic conditions.

Other value-based organizations, such as ACOs and PCMHs are eligible to qualify for this payment. This eligibility enables them to use their overlapping and distinctive capabilities in care management to capture additional revenue per patient per month.

### PREREQUISITES

To charge for the CCM, a practice must have five core competencies in place, including:

- Use of **certified electronic healthcare records** for specified purposes, such as symptom management, social resources and medication management
- Maintaining an **electronic care plan** accessible to all relevant care members, particularly the patient, and shared as appropriate under clinical conditions and HIPAA
- Ensuring a **beneficiary access to 24/7 care** through successive routine appointments with a care team member and opportunities to communicate beyond the office
- Facilitating **transitions of care** by managing referrals, providing post-discharge transitional care management and sharing a patient’s information electronically with other relevant clinicians
- Coordinating care
**Takeaways**

**Providers**
- The Chronic Care Management fee allows providers to charge $41.92 for patient encounters that are not face-to-face and empower patients to manage their conditions on a monthly basis.

**IT Analysts**
- To bill, a practice must have core competencies in its EHR system in place.

**Care Managers**
- Process changes focus on care coordination and access to care.

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**GREENWAY COMMUNITY ADVANTAGE**

Greenway Community’s care management platform allows you to seamlessly coordinate care across providers in your organization and monitor resource utilization. Respectively, these functions empower you to more easily meet the Chronic Care Management Fee’s care coordination requirements and open up appointment slots by referring patients to under-utilized resources.

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**Medicare Advantage and Risk Adjustments**

**OVERVIEW**

Medicare Advantage is a program through which Medicare benefits are paid by a third party payer, which Medicare reimburses. Medicare Advantage is not, strictly speaking, a value-based program, but it bears mentioning because of its overlap. Providers who contract with Medicare Advantage plans can include contracts and groups as diverse as Health Maintenance Organizations, Preferred Provider Organizations, fee-for-service arrangements, capitated payments and other plans. All Medicare Advantage plans must offer the same benefits as standard Medicare, meaning that they qualify for programs like the CCM.

**GETTING PAID**

In a Medicare Advantage plan, private plans generally bid for populations, and Medicare pays the payers through capitated payments. A capitated payment is a set monthly payment given for each patient, regardless of whether they come in for treatment. This capitated effect rolls down to practices and providers. While fee-for-service arrangements are certainly possible with Medicare Advantage plans, the capitated structure incentivizes the payer to work with providers under a similar plan structure.

Many payers offer providers payment adjustments or incentives based on maintaining the right diagnosis codes. Higher risk diagnoses, such as uncontrolled diabetes, command a higher fee. A patient’s out-of-pocket costs are capped at $6,700, creating a stronger incentive for payers to negotiate capitated payments with payers.

In addition to the above, some Medicare Advantage plans will also adjust reimbursement based on clinical quality performance, which is tracked through a set of measures called the Healthcare Effectiveness Data Information Set (HEDIS). The selected measures that apply vary from contract to contract.
HIERARCHICAL CONDITION CATEGORIES

To determine a patient’s risk, Medicare uses a Hierarchical Condition Categories (HCC) model. First, the patient’s demographics are considered, including age, disability status, whether institutionalized or in the community, disease state and even income.

After calculating demographic risk, Medicare analyzes the diagnoses according to risk and disease severity. There are more than 177 codes, including:

- Diabetes with varying complications
- AIDS
- Cancer
- Vascular disease
- Arthritis
- Mental conditions

Each condition maps to an ICD code. To ensure that proper risk analysis occurs, providers must give payers updated and current information on diagnoses, or face reduced payments because Medicare and the payer assume a lower population risk profile.

GREENWAY COMMUNITY ADVANTAGE

Greenway Community tracks performance measures like HEDIS, used in Medicare Advantage quality reporting, and HCC codes. It notifies you what codes are current, out of date and expiring soon so you can make sure that each patient is accurately coded, and you are accurately reimbursed.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

OVERVIEW

Passed in 2015, MACRA established a new way to pay doctors who treat Medicare patients. The legislation repeals the Medicare Sustainable Growth Rate, which was enacted in 1997 and used by CMS to control spending on physician services. While the final regulations have not been issued by CMS, MACRA bears mentioning due to its future scope. Incentive programs — such as meaningful use, the value-based modifier and PQRS — are expected to consolidate into a single program by 2019 and the new consolidated program is called the Merit-based Incentive Payment Systems (MIPS).

Takeaways

Providers

- Medicare Advantage is a program where CMS gives private payers capitated payments, and payers contract with providers and give them a “FFS +” fee structure

IT Analysts

- Reimbursement tied to risk-adjusted-factors and HCC codes — which must be renewed to maximize reimbursement
GETTING PAID

Providers will continue to work within the meaningful use program, the value-based modifier program and PQRS through 2018. Beginning in 2019, MIPS positive and negative adjustments will be based on a provider’s composite score across four domains, described below. Under MACRA, CMS will establish annual benchmarks for each domain and your organization’s pay will be adjusted up or down based on quality and comparative performance.

As outlined in July 2015, the adjustments are as follows:

<table>
<thead>
<tr>
<th>PERFORMANCE YEAR</th>
<th>PAYMENT YEAR</th>
<th>MAXIMUM NEGATIVE ADJUSTMENT</th>
<th>MAXIMUM POSITIVE ADJUSTMENT</th>
</tr>
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<td>2019</td>
<td>-4%</td>
<td>12%</td>
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<td>-5%</td>
<td>15%</td>
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<td>2021</td>
<td>-7%</td>
<td>21%</td>
</tr>
<tr>
<td>2020+</td>
<td>2022+</td>
<td>-9%</td>
<td>27%</td>
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</tbody>
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Small practices may also apply for funding to help with MIPS implementation and technical assistance.

In addition to the adjustments, providers who participate in MIPS will see payment rates (fees for service) increase by .25 percent annually, and those who are in Alternative Payment Models will see an annual .75 percent increase. The definition of alternative payment models has not been determined as of the writing of this document.

PROCESSES AND MEASURES

MIPS includes four weighted domains: quality measures, resource use, meaningful use of an EHR and clinical practice improvement activities. Quality measures will be based on existing measurements, such as PQRS; however, additional measures may be introduced. Quality measures will be assigned a 30 percent weight. Resource use, or cost, will also be weighted at 30 percent and will be measured according to the existing value-based modifier. Finally, meaningful use and clinical practice improvement will account for 25 percent and 15 percent respectively. Final measures are pending CMS guidelines.

GREENWAY COMMUNITY ADVANTAGE

Greenway Community’s robust analytics and data visualization platform empowers you to monitor and act on quality measures, resource utilization, and measure performance over time so you know where your practice is and where it should go.
MANAGING POPULATION HEALTH

Introduction to Population Health

We established in the introduction that population health management is key to taking advantage of value-based programs. But what is population health management? It is the aggregation and analysis of patient data to impact the health outcomes of a group of individuals, including the distribution of such outcomes within the group.

“Value-based programs and population health management are the future of healthcare. We made the transformation to get ahead of the curve.”

—Edward Gold, M.D.
Board Certified in Internal Medicine and Oncology & Hematology
Chief Operating Officer, Old Hook Medical Associates

To engage in population health management, practices must shift from focusing on episodic care of individual patients to treating whole populations over time. It requires a change in philosophical view from treating conditions to treating the whole person. To fulfill these lofty goals, a practice needs to identify the populations it can treat, engage and manage this population across the continuum of care, and provide personalized treatment.

This change can be challenging. Practices need new tools to manage population health, investments in care coordination resources, daily workflow changes at the point of care and administration, and the ability to measure success based on quality and cost.

This section addresses the best practices identified in literature and in practice that an organization can implement to ease the transition to population health management and maximize success.

“Who is better suited to manage population health than us? The insurers? We’re at the point of care, and want to give our patients longer and healthier lives.”

—Whitney W. Almquist
Business Manager, White Rose Family Practice

Preparing the Organization

The transformation required to properly function as an organization that emphasizes population health is broad and it impacts the practice’s structure and care delivery. The organization’s leadership, IT capabilities, care coordination resources, workflow processes and definition of success all undergo significant change in moving to a value-based delivery model.

By investing in both the resources needed to treat population health and the transition itself, an organization can secure necessary buy-in from its providers and staff and prepare for likely growing pains.

“To get the best out of the transition to value-based care, you have to prepare your organization.”

—Amanda Hobbs
Software Trainer, Premier Healthcare

LEADERSHIP

An effective transformation begins at the top—leadership must not only believe in the mission, but also facilitate the transformation. The leadership team’s composition, involvement and philosophy are key to setting the expectations of the whole organization. Quality-oriented organizations are multi-layered and multi-tiered care delivery platforms, which means employees from nurses and physicians to practice management and IT analysts must be accountable for delivering results.

There are two key components to putting the right leadership structure in place:

1] First, an organization should create a council or board to oversee the changes. While the board’s composition will vary, most successful organizations have primary care physicians and specialists at the helm. Primary care physicians are experienced with chronic disease management and are best situated to address and understand the challenges facing our system. Specialists selected should reflect those who treat chronic conditions as well, such as endocrinologists, cardiologists and mental health professionals.
2) The organization should also appoint an overall transition owner. This person is responsible for the outcomes of the transition, centralizing responsibility and the implementation of the board’s recommendations. This owner should generally be a nurse or primary care physician as they are closest to patients and have the best understanding of those patients’ total needs. The leader’s responsibilities also include staff education on transitioning to a value-based model and its financial benefits, shared through channels including town halls, weekly meetings and trainings.

"The organization’s ownership entirely bought into the transformation and participated in leading it, which is critical for a successful transition and lasting change."
—Amanda Hobbs
Software Trainer, Premier Healthcare

TOTAL BUY-IN

Such a broad change requires providers and staff to truly believe in the benefits of a value-based model. In particular, physicians’ belief in the transformation is essential to successful implementation as they have the largest impact on how your organization transforms. Understanding physicians’ motivations and challenges can help secure buy-in. In the new model, they are being asked to accomplish more for less, and they may not understand the program’s value. Showing clinical benefits in the face of financial uncertainty, from the perspective an individual physician, is key.

This is done by taking an evidence-based approach, including:

• Showing your providers the transformation will lead to improved clinical outcomes. For example, an organization could demonstrate that proactive mammograms lead to a higher diagnosis rate of preventable breast cancer.
• Minimizing the disruption to physician workflow and providing education on new processes.
• Setting measurable goals tied to clinical outcomes and demonstrating achievements along the way. A provider organization could create a goal, like increasing the number of diabetic patients with an A1C level below nine, and then use the results of risk stratification and care intervention to demonstrate progress against that goal.

GREENWAY COMMUNITY ADVANTAGE

Greenway Community provides actionable and visualized insight into cost and measure performance, so your providers and staff can see improvements as they transition to a value-based model.

"Providers are evidence-based. So if you want them to believe in these changes, show them quantified evidence that the changes you put in place result in a measurable and meaningful difference."
—Whitney W. Almquist
Business Manager, White Rose Family Practice

STAFF PREPARATION

Beyond securing belief in the new population health management mission, fully preparing your staff requires investment in human resources and proper training.

The organization must evaluate whether it has the human resources necessary for a care delivery model focused on population health management over time, rather than episodically. This model generally requires an increased investment in mid-level provider resources, such as nurse practitioners, to deliver the right level of care.

The organization must also evaluate whether some of its existing resources can be repurposed. Often, nurses can be retrained as care managers or care supervisors, which requires a lower capital and time investment than hiring new people. However, if the organization lacks the necessary resources, it may need to invest in new staff.

Once you have the right team in place, the staff must be trained on what the new mission is, why it matters to patients and the organization as a whole, and how the transformation will impact workflow. Communicating
desired patient outcomes, such as reduced Emergency Department (ED) visits, is key to getting the entire staff moving in the same direction.

These trainings can be accomplished through channels, including:

• Town halls for groups of staff, such as physicians, care coordinators and medical assistants
• Online resources or mobile apps
• Recommended literature
• One-on-one trainings with direct supervisors

“We trained some of our existing staff to handle new tasks to help our providers. Now our medical assistants spend a lot of time before the visit collecting patient information so the doctor can spend more time talking to the patient about their condition, rather than entering and collecting data.”

—Edward Gold, M.D.
Board Certified in Internal Medicine and Oncology & Hematology
Chief Operating Officer, Old Hook Medical Associates

3) Complementary culture, such total buy-in to the idea of population health management. Past participation in value-based programs, such as PCMH, is a strong indicator that the partner will commit to the mission and be ready for the change.

GREENWAY COMMUNITY ADVANTAGE
Using Greenway Community you can take de-identified patient information and evaluate a potential partner’s cost and quality in a measurable way, and see how closely aligned your organizations really are.

“We looked for practices that had a similar outlook as us to make sure the organization as a whole could succeed. One indicator was participation in some of the early value-based programs, like PCMH.”

—Edward Gold, M.D.
Board Certified in Internal Medicine and Oncology & Hematology
Chief Operating Officer, Old Hook Medical Associates

NETWORK EVALUATION
An organization that seeks to create a value-based network will often look for partners to join its direct network or referral network. But what is the best way to evaluate these potential partners? An organization must first identify the specialists and primary care providers it needs based on the population it serves. If the organization treats a population with a high incidence of heart disease, it may need more cardiologists, or of it treats a population with a high incidence of diabetes, it may need more endocrinologists.

Partner organizations should be measured against three tenets:

1) Quality, assessed based on common measures such as those defined for PQRS or ACOs.
2) Healthcare expenditures or costs, based on hospital readmissions, overall cost per patient per month and facility costs.

Hospitals/Acute Relationships
Hospital admissions and readmissions are key drivers of healthcare costs nationally, so developing relationships with acute care facilities based on quality, cost, and culture is critical to your success. To lower costs, your organization needs to reduce hospital admissions and readmissions, identifying those patients who frequent hospitals through risk stratification and working together to identify ways to minimize these trips.

Ideal hospital partners should be oriented towards increasing the transparency of care when admitting and discharging patients. Primary care physicians and your organization must have visibility into to why patients are admitted, how they are treated, and their post-discharge instructions to increase the efficacy of any patient’s treatment across the continuum of care.
Greenway Community is able to pull information from disparate sources, including acute care facilities and their EHRs so you know when patients are moving in and out of the hospital.

“We maintain a tight relationship with a local hospital and their staff to make sure everybody has the right information about our patients.”

—Amanda Hobbs
Software Trainer, Premier Healthcare

**Community Relationships**

When developing your network, consider relationships not only with healthcare organizations, but also with other community groups. Treating the whole person requires understanding their societal and personal support network, as it often has a profound impact on long-term health.

An individual may be unable to adhere to his or her care plan for reasons unaccounted for by the practice of medicine. For example, a patient may be unable to stick to a diet plan because he does not have access to the right food resources, or he may be unable to attend a follow-up appointment because he cannot get a ride to the office. A patient may have a weak social network, increasing the effects of depression and slowing recovery.

Partnerships with patients’ support networks make it possible to develop treatment plans based on their unique circumstances. Relationships with charities and non-governmental organizations (NGOs) that distribute food and cater to the homeless, as well as partnering with religious organizations and a patient’s family, can support patients in their own personal care.

“In order to succeed and stay viable in the future it will be imperative to coordinate care and utilize services available within our medical neighborhood. This will allow us to not only provide their medical care, but assist in coordination of social needs, transportation access, along with food and meal preparations.”

—Betty Evans
C.E.O., Oak Street Medical

**Takeaways**

**Providers**

- Leadership must drive the transformation to a value-based organization by securing total buy-in from all staff members.
- Evaluate and build the medical neighborhood by partnering with hospitals, specialists, other providers and the patient’s community.

**Care Managers**

- Train and repurpose staff or hire new team members to fill care coordination roles as well as facilitate care management and transitions of care.
SPREADING THE NEWS

Because care coordination is critical to the success of a value-based organization, increasing the transparency of care is important. Patients need to understand the change and the new resources available to them. Practices and providers also need to alleviate privacy concerns when protected clinical data is shared by helping patients understand why this exchange is necessary.

Patient education should include:

- Telling patients at the front desk what changes are occurring under the new model and what that means to them, such as increased access to healthcare services. The front desk should also explain why a patient’s protected information would be shared between partner organizations.

- Beyond the front desk, patient education can take the form of website updates, town halls, direct mail or email campaigns, and social media.

Informing the patient of the change is important not only to protect the organization from legal ramifications, but also to ensure that patients take advantage of the services available to them.

“We educated our patients before the change so they knew when, how and why we would share their health information, and importantly we told them what it would mean for their day-to-day care.”

—Amanda Hobbs
Software Trainer, Premier Healthcare

GREENWAY COMMUNITY ADVANTAGE

Greenway Community Analytics, a visualized and integrated analytics platform, empowers your organization to hierarchically manage quality and costs at every level of the organization through actionable data visualization.

“’We’d been collecting data for years without using it. I still can’t believe it; did we really think we were just gathering so it could sit on some server somewhere? When we started actually using the data, we couldn’t believe what a difference it made.”

—Whitney W. Almquist
Business Manager, White Rose Family Practice

GETTING THE COMPLETE PICTURE

To make the best use of analytics, an organization must compile an accurate data set of its population’s health. Getting a complete picture requires multiple types of data for direct and comparative use from several sources.

An organization needs both claims and clinical data. Claims data alone cannot provide insight into the health of a population because it is specifically designed to service payers and focuses on the patient’s treatment cost rather than clinical facts. Claims data also may not capture a patient’s surgical history or medication allergies as that information is not assigned a billing code. It is also frequently outdated with certain procedures and diagnoses going un-coded for months at a time.

With these factors in mind, an organization must also rely on the clinical data in its EHRs to fully understand a patient’s health. But, this data is only as good as its source. To avoid missing critical information, an organization needs a well-integrated IT system and shared information across the enterprise. Its ambulatory practices should be able to exchange clinical care summaries to give providers the most up-to-date patient information and ensure patients are assigned appropriate clinical risk levels. Hospitals and other providers of acute care should be connected to the data so that critical information is available on ED visits. This connectedness enables

Technology

The change to a value-based organization requires adoption of health information technology (HIT) to measure outcomes, identify at-risk patients and successfully report on quality and cost measures.

Data is essential to operating on an evidence-based model. Organizations that rely on data can more effectively identify at-risk populations prime for intervention, reducing healthcare expenditures by lowering hospital admissions and readmissions. Data also demonstrates the clinical value of a population health model over one that manages care episodically.
providers to perform medication reconciliation, help enforce post-discharge instructions, and identify where high and avoidable expenditures take place.

Finally, patients themselves are important sources of clinical data. Gaps in charts should be completed at the point of care, and patient data collection should be integrated into the practice’s workflow. Other sources of patient information, such as health information exchanges and immunization registries can also provide useful insight, such as a patient’s vaccination history.

GREENWAY COMMUNITY ADVANTAGE
Greenway Community pulls both claims and clinical data from variety of resources, such as other EHRs, HIEs, hospital systems and payers, so you have a complete picture of a patient’s health.

“You can’t just rely on one source or one type of data. Claims data is meant for financial risk—it’s not complete. The integrity of clinical data depends on where it comes from. To get an overall view of a patient’s health you need claims and clinical data from multiple sources.”

—Jason Steeprow
Chief Operating Officer, South Tabor Family Physicians

RISK STRATIFICATION
Organizations successful in managing population health employ risk stratification—a statistical process to determine the likelihood of unwanted outcomes—to identify patients at risk of hospitalization or health complications. These organizations break patients into buckets based on their conditions and treatability, and proactively contact patients to bring them in for necessary care interventions. When transitioning to a value-based organization, one of the first things an organization will do is risk stratify its patients to gain an overall view of the population’s health.

How a practice defines its buckets will depend on the types of patients it treats. A typical risk stratification breaks patients into high risk, rising or medium risk, and low risk brackets. High risk patients are those who consume the most healthcare services and are most likely to be hospitalized. Rising risk or medium risk patients are generally those who have chronic conditions, and low risk patients are a practice’s healthy patients. Other models risk stratify based on more defined clinical buckets. For example, one model may place emphasis on patients with chronic conditions out of control for preventable reasons, patients near the end of their life, patients with chronic conditions that have complications, patients with stable chronic conditions and healthy patients.

However you define risk, any successful organization will identify its patients with repeated hospitalizations and readmissions. These patients consume the most healthcare services in the acute environment, driving up costs. Often, these trips to the ED are visits that an urgent care or primary care physician could have addressed, or they were preventable through medication and care plan adherence.

Finally, it is important to measure risk intelligently and determine your ability to positively impact a patient’s health. For example, patients who are at the end of their life do not need help with diet and exercise; rather, they need assistance planning end-of-life instructions and with acceptance of death. The use of care management resources, typically midlevel providers, for patients in this stage would be a costly misallocation of resources. However, a patient who is at high risk because of uncontrolled diabetes is a prime target for intervention by a care manager, and a potential source of cost savings.

GREENWAY COMMUNITY ADVANTAGE
Greenway Community uses proprietary technology to tell you not just who is at high risk, but also your ability to impact the patient so you can maximize the use of your care management resources.

REPORTING
Value-based organizations commonly use HIT to track reporting requirements under the aforementioned payer contracts. However, reports can also be used to target gaps in care and identify patients to bring in for preventive care. Reports may be run daily or monthly. For example, it is a good practice to run a daily report on which patients have been admitted or readmitted to the hospital so you can actively manage their transitions of care. Other reports that track
the emergence of chronic conditions, such as those based on patients with a high body mass index or A1C level, may be run monthly to identify rising-risk patients.

Regardless of the cadence of reports, ongoing analytics and stratification are critical to a value-based organization and are the cornerstone to ensuring you know who needs care and when.

**GREENWAY COMMUNITY ADVANTAGE**

Greenway Community allows you to track and measure performance as well as identify open gaps of care with at-a-glance, customizable physician dashboards that visualize clinical and financial performance.

"Data has changed the way we practice healthcare. It has the power to change patient outcomes and improve lives—we’ll never go back to the way things were."

—Whitney W. Almquist
Business Manager, White Rose Family Practice

**Care Coordination and Patient Engagement**

After identifying patients you can help through data and analytics, the question becomes what to do with those patients. Care managers, sometimes called care coordinators, are embedded in the organization to address that issue.

A care manager is a person with clinical experience, generally a nurse, who acts on the monthly and daily reports generated by your HIT. After receiving or running reports and risk stratifying patients, he or she will schedule patients for appointments, manage their transitions of care, and engage with them before and after an appointment. Care managers’ key responsibilities are to keep patients out of the ED, empower patients to self-manage their conditions, and facilitate transitions of care. How a care manager interacts with patients will generally depend on the risk level at which a patient falls, with more proactive and involved approaches for patients at a higher risk.

**GREENWAY COMMUNITY ADVANTAGE**

Greenway Community’s care management platform, Greenway Community Manager, allows you to manage care coordination activities not just at the frontline of care, but also at the supervisor level. This macro-level view displays managers and patients across the organization, allowing supervisors to assign care managers to patients and make the best use of resources.
“The first and most important thing we did when transitioning to a value-based organization was embed care coordinators into the practice.”

—Edward Gold, M.D.
Board Certified in Internal Medicine and Oncology & Hematology
Chief Operating Officer, Old Hook Medical Associates

CARE COORDINATION OVERVIEW

Care managers should actively run reports and analytics that indicate when a patient is at risk of becoming a high healthcare consumer. For example, care managers should actively monitor who in their population has an A1C level over nine, patients over 55 who have not had mammograms or colon cancer screenings, or those who have a high body mass index. The focus of these metrics is identifying the potential onset of the most common chronic conditions.

After identifying these high-risk patients, the care manager’s role is to engage them, depending on their level of risk. Successful care managers employ a variety of communication tools, including:

- Phone calls
- Text messages
- Mailings
- Email
- Secure messages through a patient portal
- Passive contact — waiting for patients to show up and informing them what further care they need at the front desk

If a patient is particularly prone to onset, the care manager should contact him or her proactively through multiple means and with multiple attempts until contact is established. Once the patient is reached, he or she should be scheduled to come in to see the appropriate clinical staff for screenings, labs, and other procedures based on his or her condition. Depending on the patient’s history, the care manager should also remind the patient of his or her appointments prior to the scheduled date and day to help decrease no-shows.

After the patient’s initial appointment, the care manager should discuss the patient’s care plan with the primary care physician. This discussion enables the care manager to identify and schedule necessary follow-up appointments. Whether these appointments are with specialists or another primary care provider, it is important for the care manager to track what care the patient receives and what is outstanding.

It is also important to set and track measurable goals with each high-risk patient. For example, if a patient is diabetic, the goal could be to lose a certain number of pounds, compliance with a diet set at certain caloric and carb intakes, or a target A1C level. Following up on these goals builds an understanding of the patient from a clinical view and helps hold the patient accountable.

The care manager must also engage the patient’s community. Caregivers and family who support the patient all need to know how they can help navigate their treatment and encourage compliance. Finally, discussed in detail below, patients and their social support network should be given relevant education materials.

With respect to low-risk patients, the care manager’s focus is on providing access and a “light touch” approach. Patients should have access to your organization through multiple points, such as patient portals, phone lines, email, your website, and social media. These access points should make it easy to schedule appointments, and communicate when and why healthy patients should have appointments. To help with this process, successful care managers often run annual appointment recalls, calling in all patients who have not had their annual screenings or exams in the past year.

GREENWAY COMMUNITY ADVANTAGE

Using Greenway Community, you can assign patients and custom care plans in a visual way that makes it easy to track and to see where the patient is on their path to a healthier life.
“Our care coordinators are registered nurses who assist with transitions of care. They track whether we are meeting our objectives for our individual patients and the overall population.”

—David Steed
Ambulatory Applications Manager, Floyd Medical Center

TRANSITIONS OF CARE

Managing transitions of care from the ED is critical for improving population health, preventing future hospitalizations and reducing healthcare costs. Acute events are not only disproportionately expensive, but also traumatic, so keeping patients out of the hospital after admission is an important goal.

A care manager should identify patients with admissions and readmissions to the hospital on a daily basis. This process can be accomplished through daily reporting, if the two systems are integrated, or through a managed relationship with the hospital and its staff.

If a care coordinator identifies a patient currently in the hospital, they should send a nurse or primary care physician to the hospital to ensure the patient’s care is transparent, and the hospital has all the information they need to best treat the patient.

Post-discharge, the care manager should take several steps to manage the transition of care and transfer to discharge.

• The care manager frequently performs medication reconciliation and reviews discharge instructions with the patient to avoid dangerous complications that may lead to another hospitalization.
• They also schedule follow-up appointments with the patient’s primary care physician and other specialists he or her may need to see.
• The best care managers ensure the patient had a “real” emergency and gives advice if the patient could have used other healthcare resources to treat his or her problem. Many conditions can be handled by an urgent care facility, helping the patient avoid costly hospital bills and keeping the healthcare organization’s costs down.
• The care manager should set measurable goals with the patient and monitor his or her progress through personalized communications. Activating the patient’s support network and keeping them apprised of a patient’s progress, treatment, and care plan — within the confines of HIPAA guidelines — is critical to helping high-risk patients succeed.

GREENWAY COMMUNITY ADVANTAGE

Greenway Community has built-in custom dashboards that can tell you when and where your patients are admitted to the ED so you can schedule follow-up and other services with your providers in a timely way.

“When patients are discharged from the hospital, our care coordination team places an initial phone call to assess any immediate needs, reviews their discharge medication list and answers any questions, and schedules a follow-up appointment with their primary care provider. The goal is to address all care needs while the patient is here in the office; this includes any immunizations, screenings, and review of current care condition goals.”

—Betty Evans
Chief Executive Officer, Oak Street Medical

PATIENT EDUCATION

An essential tenant of population health management is enabling patients to care for themselves at home by providing tools and education. In-office care is only the first step to recovery, so care managers should point patients to resources that help them understand and proactively manage their condition. Patient education should include both passive and active tools, ranging from brochures and disease guides to mobile apps that assist with carb counting or devices to monitor blood pressure.

Education should also take place “in the classroom” through online and in-person support groups that allow patients to share and learn from each other’s experiences. Care managers can refer patients to community partners, such as hospitals, or the organization
can offer and promote its own group classes. For example, if the population you are treating has a high rate of diabetes, you could offer a group class on taking insulin, using an insulin pump and carb counting.

As with all care coordination outreach, a care manager should disseminate educational materials through a variety of methods, such as mailings, email, patient portals, online, social media, during office visits, and by phone. By increasing the number of channels used, you also increase the chances of the right information reaching and impacting your patients.

GREENWAY COMMUNITY ADVANTAGE

Greenway Community seamlessly pushes patients identified as at-risk from the analytics platform to the care management platform. It also empowers care managers at each level of the organization, not just the frontline, to coordinate care across the enterprise.

“We utilize what we call ‘Focused’ appointments for same day access; this allows patients to be seen in the office rather than presenting at the urgent care or emergency room. If the patient chose to go to either of these facilities for treatment, once our office is notified of the service provided our care manager contacts the patient to ensure they are stable, and all needs are met. If their presenting diagnosis could have been handled within the office, this time is then utilized as an educational opportunity to contact our office first for triage.”

—Betty Evans
Chief Executive Officer, Oak Street Medicaid

Process Changes

In addition to investing in HIT and embedding care coordinators, organizations should undertake a series of process changes to enhance the patient experience and maximize efficiency. These efforts help organizations treat the whole patient and population to better manage chronic conditions and avoid preventable costs. The changes include workflow adjustments, increased patient access, disease screening procedures, adopting a shared decision-making process, and taking collaborative approach to care. Specific best practices to make these changes as easy as possible for your organization are detailed below.

Takeaways

Care Managers

- Engage patients intelligently according to their risk profile and social history and employ a variety of communication tools to extend reach
- Craft plans with patients to ensure continued engagement and care coordination
- Carefully manage transitions of care and ED discharges to maximize impact
- Educate patients so they can manage their conditions out of the office
WORKFLOW

In a value-based organization, certain workflow changes can improve patient-provider communication and the sharing of information across the continuum of care.

First, the medical assistant or other designated staff should be positioned to help providers speed up visits while ensuring complete and accurate documentation. This team member should see the patient before the provider and verbally cover commonly requested information so the provider is properly debriefed. Topics to cover include:

- All present and past medications
- Any health reminders in the EHR
- Open care gaps or screenings
- Future appointments and follow up

After the visit, it is the medical assistant’s role to communicate open care gaps and required follow-up to the care manager.

In addition to enhancing the role of the medical assistant, providers should center visits around the patient’s entire condition, and not just the reason he or she is in the office for this particular appointment. After getting patient information from the medical assistant, the provider should determine the patient’s need for treatment or follow up from the provider or others in the network. These next steps should then be entered into the EHR system and communicated to other providers through detailed notes. To assist the care manager, the provider should consider modifying the care plan to essentially force the patient back into the office by limiting prescription refills or other means.

“You need to change your processes to make sure the patient comes into the office when they’re supposed to. Don’t rely on the patient to schedule a follow-up appointment or discover that they need one. Take care of that at the point of care.”

—Edward Gold, M.D.
Board Certified in Internal Medicine and Oncology & Hematology
Chief Operating Officer, Old Hook Medical Associates

SAME-DAY ACCESS

Improved access to clinical resources empowers patients to better manage their conditions. Ultimately, a value-based organization should aim to provide patients with same-day access to its facilities, making them less reliant on the ED.

Best practices to help patients gain access to your facility include extended evening and weekend hours. During the traditional work week, organizations can reserve time in providers’ schedules to book day-of appointments. This strategy gives the practice flexibility to bring in patients when they require urgent, but non-emergency, care.

Same-day access means a patient with a rash may avoid the ED where he or she would wait for hours and incur serious expenses. It also means patients without the ability to take off work or leave the home during typical office hours are seen, capturing more revenue-generating opportunities.

GREENWAY COMMUNITY ADVANTAGE

Greenway Community visualizes open care gaps using provider dashboards so you can act on information during an appointment and close those gaps.

GREENWAY COMMUNITY ADVANTAGE

Greenway Community shows you what your over-utilized and under-utilized resources are from the facility down to the provider level, empowering your practice to shift resources where you need them most.
“Throughout our transformation, two of our major implementations were the creation of our same-day focused appointments, as well as our care coordination team. The feedback from our patients has been phenomenal, and they continue to be pleasantly surprised when they are contacted for follow-up on inpatient stays, and our care plan goals.”
—Betty Evans
Chief Executive Officer, Oak Street Medical

THE COMPREHENSIVE CARE VISIT

Many successful value-based organizations have implemented the comprehensive care visit, an exam similar to a patient’s annual exam that covers screening for costly chronic conditions. During these visits, the patient may see one or more providers to be screened for conditions like depression, falls risk, hypertension, diabetes and obesity. Benefits of the visit include:

• Prevention of emerging or borderline chronic conditions
• Opportunity to catch at-risk patients and address health needs before hospitalizations
• Ability to schedule the patient for follow-up, depending on the results of the screening

Additionally, comprehensive care visits—sometimes called wellness visits—are often quality measures in value-based programs.

A critical component to comprehensive care visits is not relying on the patient to schedule them. Your care management team should regularly run reports on patients who have missed their annual exam and proactively reach out to them. Practice-wide efforts promoting the benefits of a comprehensive care visit and catching chronic diseases early will also encourage patients to come in. Distribution channels should include the front desk, mail, email, the practice website, social media and telephone campaigns for nonresponsive patients.

GREENWAY COMMUNITY ADVANTAGE

Greenway Community’s dashboards show who has and hasn’t been in for a wellness visit, and allows you to send that information seamlessly to its care management platform so you can reach out and schedule those patients for a visit.

“We use our comprehensive primary care visit to look at a lot of things. We make sure our patients have had all their annual screenings and also look into whether a patient is at risk for common chronic conditions. That way we can catch medical problems before they become too serious.”
—Amanda Hobbs
Software Trainer, Premier Healthcare

SHARED DECISION-MAKING

Involving patients in their care is critical to empowering them to manage their own conditions. This should go deeper than education and involve patients in deciding their best course of treatment.

Information sharing is a prerequisite to patients making smart decisions about their health. Providers should use their expertise to apprise patients of their care options, including the potential benefits and disadvantages of each course of action. The conversation should:

• Introduce the choices
• Explain the options
• Discuss patients’ preferences and values, such as quality of life, and which options most closely align

In addition to provider consultation, tools like decision aids that clearly outline treatments can help patients make the right decision and give them information to review at home. The benefits of shared decision-making are evident, with 20 percent fewer patients selecting invasive surgery than those not engaged by their doctor.⁷

COLLABORATIVE CARE MEETINGS

Population health is dependent upon coordination across the continuum of care—and this coordination must be more than merely pushing tasks back and forth. **Care coordinators, primary care physicians and specialists should regularly discuss patients they are treating** and how they can best help those patients. Patients who have been discharged from the hospital, have been recently diagnosed with a chronic condition, or are developing complications should be discussed and action plans established.

“Our providers and clinical staff huddle on a day-to-day basis, and it’s a way to keep us all on the same page. The team discusses where they are at for the day and where they need to be at the end of the day. With the moving parts involved, it’s invaluable.”

—Whitney W. Almquist
Business Manager, White Rose Family Practice

GREENWAY COMMUNITY ADVANTAGE

Greenway Community’s care management platform allows you to seamlessly manage a patient’s care plan over time across multiple providers. It also has built-in dashboards that track wellness visits, so you know who to bring in for a checkup. Finally, Greenway Community fully integrates with your EHR, so you don’t have to spend time entering data in multiple systems at the point of care.

Measuring Success

Managing population health is a dynamic effort that will require change and experimentation over time. **It is important to measure the success of your process changes, and look at their impact on finances, clinical outcomes and the patient experience.**

Key members of your team, including care managers and providers, should **meet monthly or, even better, weekly to discuss processes, procedures, goals and progress measured by clinical and financial data.** Examples of clinical milestones include:

- Percentage of the population given mammograms
- Comparison of past diagnoses rates for chronic conditions
- All diabetics given an A1C test within a certain period of time
- Percentage of the population given their annual exam

Takeaways

**Providers**

- **Process:** Give your patients same day access to your facilities so they see you before going to the ED
- **People:** Collaborate and meet with the clinical team frequently to make sure everyone stays on the same page

**Care Managers**

- **Process:** Provide and promote comprehensive care visits, or wellness visits, to catch clinical problems before they advance too far
Examples of financial milestones include:

• Total healthcare expenditures/savings
• Patient capacity and average visit time
• Use of high-priced resources rates, such as the emergency room

The purpose of these meetings is to gain quantifiable insight into what changes and procedures are working and what is not. Your organization should be agile—if a process or method does not work, discontinue it. For example, if reaching out to patients for a preventive EKG shows no increased incidence in the diagnosis of heart disease, then it may not be the best procedure to improve quality or lower costs. On the other hand, if contacting patients for colorectal screenings leads to increased cancer diagnoses, embed that into your practice at a cadence that makes sense for your organization and patient population.

Your patients should be another major source of feedback. Satisfaction surveys and reports can provide an overview of how patients perceive your practice and their treatment. However, to gain true insight, bring patients into the room to contribute through conversation.

Establishing a patient advisory council can provide important insights. In the words of one provider, “nobody really understands patients until they hear from them.” As an example, you may find that patients are regularly missing follow-up appointments. After speaking with your patient council, you may learn that your population has low access to transportation and have the opportunity to craft a solution, such as remote visits or using community resources.

Finally, don’t hoard all of this information. Rather, share it with the organization so your staff and providers can see how they are impacting the health of your patients.

“Hearing from our patients as to what is important to them and the ways in which we can improve on the care we provide is very important to us. We have utilized satisfaction surveys and recently have developed a patient advisory council to assist us in this communication. We have also implemented an educational TV screen for the lobby which not only includes educational videos, but also includes additional communication about services we provide, along with services and support groups in the local community.”

—Betty Evans
Chief Executive Officer, Oak Street Medical

GREENWAY COMMUNITY ADVANTAGE
Greenway Community tracks clinical and financial performance over time, so you know your current state, where you’re going, and can identify areas of improvement.
THE GREENWAY COMMUNITY ADVANTAGE
THE GREENWAY COMMUNITY ADVANTAGE

As you’ve seen in this guide, population health can be a challenging, but highly rewarding model for your healthcare organization. To be successful, you need to understand the models available to you, secure buy-in, adjust your processes and be prepared to report, measure and evaluate your progress. With Greenway Community, Greenway Health wants to be your partner in transforming your organization.

Greenway Community, Greenway Health’s population solution, can help you participate in value-based programs and ease the transition to a value-based world. It has three components. The tool includes Greenway Community Analytics, an integrated analytics platform that aggregates claims and clinical data from multiple sources and visualizes it in an actionable way—all while stratifying patients by risk and your ability to impact them. Greenway Community Manager is a care coordination tool that empowers organizations to manage care not just at the practice level, but across the enterprise. Finally, Greenway Exchange is an industry-leading clinical connectivity platform that allows practices to share clinical data across all EHRs.

To learn more, please contact a Greenway Health representative at 866.242.3805 or visit our website at www.greenwayhealth.com/solution/population-health-software
USEFUL CHARTS AND MEASURES
## USEFUL CHARTS AND MEASURES

### ACO MEASURES

#### BETTER CARE FOR INDIVIDUALS

**Patient/Caregiver Experience**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Getting timely care, appointments, and information</td>
<td>Health promotion and education</td>
</tr>
<tr>
<td>How well your doctors communicate</td>
<td>Shared decision-making</td>
</tr>
<tr>
<td>Patient's rating of doctor</td>
<td>Health status/functional status</td>
</tr>
<tr>
<td>Access to specialists</td>
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</tbody>
</table>

**Care Coordination/Patient Safety**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory sensitive conditions admissions: COPD</td>
<td>Discharges for patients over 40 with COPD, asthma or acute bronchitis ICD-9 codes/Patients 40 and over</td>
</tr>
<tr>
<td>Ambulatory sensitive conditions admissions: Congestive heart failure</td>
<td>Discharges for patients over 18 with heart failure/patients over 18</td>
</tr>
<tr>
<td>Percent of PCPs who successfully qualify for an EHR incentive program payment (double weight)</td>
<td></td>
</tr>
<tr>
<td>Medication reconciliation: Reconciliation after discharge from inpatient facility (documenting reconciled drugs)</td>
<td>Patients who had reconciliation of discharge meds with current medical list in outpatient record/all patients over 18 (two rates, 18–64 and 65+)</td>
</tr>
<tr>
<td>Screening for fall risk. Three aggregate rates:</td>
<td></td>
</tr>
<tr>
<td>A. Patients screened for future fall risk at least once in 12 months</td>
<td></td>
</tr>
<tr>
<td>B. Patients who had a risk assessment for falls completed within 12 months</td>
<td></td>
</tr>
<tr>
<td>C. Plan of Care for Falls: Patients with a plan of care for falls document within 12 months</td>
<td></td>
</tr>
<tr>
<td>A. All patients over 65. B/C. All patients over 65 with a history of falls.</td>
<td></td>
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</tbody>
</table>

#### BETTER HEALTH FOR POPULATIONS

**Preventative Health**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
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<tbody>
<tr>
<td>Influenza immunization</td>
<td>Adult weight, screening and follow up (when BMI goes out of normal parameters, follow-up plan documented during encounter)</td>
</tr>
<tr>
<td>Patients who received immunization or reported receipt of immunization/All points over 6 months of age</td>
<td>Patients with documented BMI, and when outside normal parameter, documented follow-up/all patients over 18</td>
</tr>
<tr>
<td>Pneumococcal vaccination</td>
<td>Tobacco use assessment and cessation intervention (if IDd as user, cessation counseling)</td>
</tr>
<tr>
<td>Number of patients who say that have had a PNU shot/CAHPS respondents 65+ responding</td>
<td>Patients screened for tobacco use during 2-yr period and received cessation counseling if IDd as user/all patients over 18 seen for at least two visits or one preventive visit</td>
</tr>
<tr>
<td>Depression screening [screen 12 and up + follow up] patients screened for depression using age-appropriate tool and follow-up plan/all patients over 12</td>
<td></td>
</tr>
<tr>
<td>Colorectal Cancer screening [Screening for CC/patients 51–75]</td>
<td>Mammography screening</td>
</tr>
<tr>
<td></td>
<td>One mammogram per year/Women 42–68</td>
</tr>
<tr>
<td></td>
<td>Blood pressure measured within preceding 2 years</td>
</tr>
</tbody>
</table>
### ACO MEASURES

#### At-Risk Population

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Diabetes composite A1C (less than 8.0)</td>
<td>Blood pressure control BP adequately controlled, must be less than 140/90 (upper limit/patients 18-85)</td>
</tr>
<tr>
<td>Diabetes composite LDL (less than 100)</td>
<td>Ischemic vascular disease Lipid profile and lipid control Patients with completed lipid profile with result &lt;100mg/dl/patients 18+ discharged for AMI, CABG, PCI or IVD</td>
</tr>
<tr>
<td>Diabetes composite blood pressure (less than 140/90)</td>
<td>Ischemic vascular disease use of aspirin Patients who used aspirin/patients discharged for AMI, CABG, PCI, or IVD</td>
</tr>
<tr>
<td>Diabetes composite tobacco non-use Y/N</td>
<td>Heart failure: Beta-blocker therapy for left ventricular systolic dysfunction Patients given beta-blocker therapy in outpatient. Setting or at hospital discharge/Patients 18+ with diagnosis of heart failure or with a current or prior LVEF &lt; 40%</td>
</tr>
<tr>
<td>Diabetes composite aspirin (on aspirin with diagnosis of ischemic vascular disease unless contraindicated)</td>
<td>CAD composite: LDL cholesterol Patients LDL-C &lt; 100 mg/dl, or patients with a higher level and documented plan to et a lower one/patients 18+ with CAD</td>
</tr>
<tr>
<td>Diabetes mellitus: A1C (less than 9.0). Not risk adjusted.</td>
<td>CAD composite: ACE, ARB, treatments Patients with ACE or ARB therapy/Patients with CAD</td>
</tr>
</tbody>
</table>

#### ADMINISTRATIVE CLAIMS PROCESS MEASURES

Follow-up after hospitalization for mental illness [NCQA, Care coordination]

Use of right-risk meds in the elderly [NCQA, Patient Safety]

Lack of monthly INR monitoring for warfarin users [CMS, patient safety]

Use of spirometry to diagnose COPD [NCQA, clinical care]

Statin therapy for patients with coronary artery disease [CMS, clinical care]

Lipid profile for beneficiaries who are on lipid lowering medications [resolution health, clinical care]

Osteoperosis management in women over 67 who had a fracture [NCQA, clinical care]

Dialated eye exam for patients under 75 with diabetes [NCQA, clinical care]

HbA1c testing for patients under 75 with diabetes [NCQA, clinical care]

Urine protein screening for patients under 75 with diabetes [NCQA, clinical care]

Lipid profile for patients under 75 with diabetes [NCQA, clinical care]

Lipid profile for patients with ischemic vascular disease [NCQA, clinical care]

Antidepressant treatment for depression [NCQA, clinical care]

Best cancer for women under 69 [NCQA, clinical care]
**ADMINISTRATIVE CLAIMS OUTCOMES MEASURES**

Used for quality tiering if a practice does not meet the reporting criteria of the PQRS incentive

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
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<tbody>
<tr>
<td>Number of admissions for bacterial pneumonia (AHRQ)</td>
<td></td>
</tr>
<tr>
<td>Number of discharges for UTI (AHRQ)</td>
<td></td>
</tr>
<tr>
<td>Number of dehydration admissions (AHRQ)</td>
<td></td>
</tr>
<tr>
<td>Number of discharges for uncontrolled diabetes</td>
<td></td>
</tr>
<tr>
<td>Number of discharges for short term diabetes complications</td>
<td></td>
</tr>
<tr>
<td>Number of discharges for long term diabetes complications</td>
<td></td>
</tr>
<tr>
<td>Number of discharges for lower extremity amputation for diabetes</td>
<td></td>
</tr>
<tr>
<td>Number of admissions for COPD</td>
<td></td>
</tr>
<tr>
<td>Percent of population with admissions for heart failure</td>
<td></td>
</tr>
<tr>
<td>Rate of provider visits within 30 days of discharge</td>
<td></td>
</tr>
</tbody>
</table>