Quality and Value: Engaging Health Care Systems to Improve Chronic Disease

Hawaii Department of Health (DOH) - Healthy Hawaii Strategic Summit

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Learning Objectives

Identify strategies to increase provider engagement in our programs by:

- Expanding our understanding of health care quality reporting programs and other requirements.
- Identifying ways to align with and leverage existing provider requirements.
- Generate ideas to maximize our value and reduce burden for recruited clinics/partners.

Health System/Provider Priorities

- Compliance and best practices.
- Quality reporting/payment models.
- Internal incentive programs.
- Organizational or community initiatives.
- Personal passions.

Health System/Provider Challenges

- Competing priorities.
- Inconsistent standards for metrics.
- Documentation and workflow requirements.
- Misaligned financial incentives.
- Electronic health record (EHR) limitations or complexities.

Tactics

1. Increase awareness.
2. Adjust approaches.
3. Align initiatives and activities.
4. Provide support.

Quality Reporting Programs

Healthcare Quality Reporting Programs

- Purpose:
  - Improve quality of care and patient safety.
  - Control costs.
  - Promote Interoperability and data sharing
  - Encourage preventive care and care management.
  - Increase accountability and transparency.
- Through payment incentives, payment reductions and data reporting and publication

Healthcare Quality Reporting Programs

- Most of the programs are requirements of government agencies or laws.
- Different programs apply to different facility types.
- Different eligibility and reporting requirements.
- May or may not affect payment/reimbursement.
- Requirements change every year.

Outpatient/Clinics

Outpatient Quality Reporting Programs

- Centers for Medicare & Medicaid Services (CMS).
  - Quality payment program (QPP).
- Health Resources and Services Administration (HRSA).
  - United data system (UDS).
- Patient-centered medical home (PCMH).

CMS Quality Payment Program (QPP)

- Required for eligible providers and **tied to payment/ reimbursement.**
- **Objective:** To help transition from FFS to value-based payment with reimbursement based on outcomes, not volume.
- Two tracks:
  - Merit-based incentive payment system (MIPS).
  - Advanced alternative payment models (APMs).
    - Accountable care organizations (ACOs).
    - Making care primary.
    - Medicare Shared Savings Programs

CMS – QPP: MIPS

Merit-Based Incentive Payment System

Most basic level of requirements and payment penalties.

- Four categories:
    1. Quality reporting – electronic clinical quality measures (eCQMs).
    2. Promoting interoperability – using certified EHRs.
    3. Improvement activities.
    4. Cost (based on Medicare part B claims).
- Requirements change each year.

CMS – QPP: APM

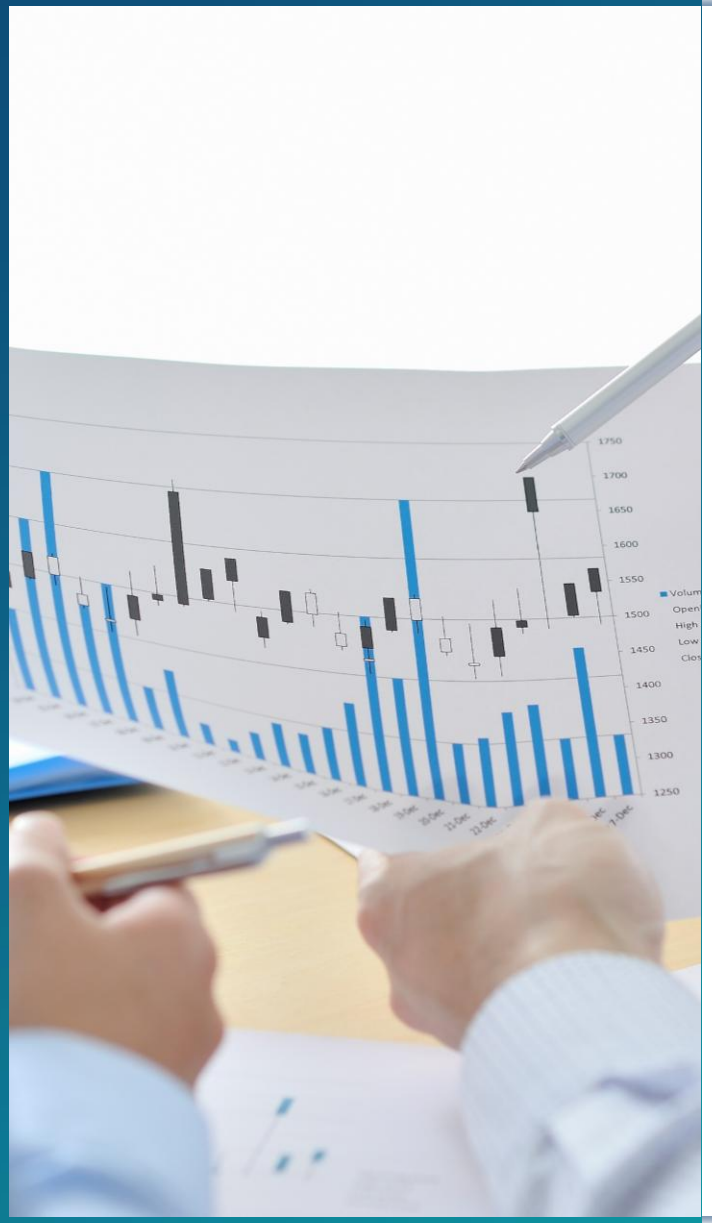
Advanced Alternative Payment Models

- Offers higher incentives to providers to switch from FFS billing to high-quality, cost-effective care.
- **More money tied to performance than with MIPS.**
- New APM programs coming out of CMS Innovation Center all the time.
  - Quality Reporting – electronic clinical quality measures.
  - Advanced care delivery concepts, example:

    Risk stratification and empanelment, care management, behavior health integration, comprehensive medication management, patient engagement, care planning and goal setting.

QPP Measures

- Over 200 measures for QPP.
- MIPS reporting – may be self-selected or part of a measure group.
- APM reporting – the program determines the measures required.
- Most common chronic disease quality measures are included.



HRSA – UDS

- Required program.
- Federally qualified health centers (FQHCs).
- High-level program overview:
  - Required reporting for FQHCs.
  - No financial incentives or penalties for performance.
  - Used as a “scorecard.”
  - Encourages improvement year-to-year.

UDS Measures
(support chronic disease management)

- Controlling high blood pressure.
- Statin therapy for prevention/ treatment of cardiovascular disease (CVD).
- Diabetes A1c - poor control.
- Cancer screening.
- Tobacco screening and cessation counseling.
- Preventive care and screening body mass index (BMI).
- Weight assessment and counseling for nutrition and physical activity.

Patient-Centered Medical Home (PCMH)

National Committee for Quality Assurance (NCQA)

- Must report annually to maintain certification.
- Requirements include implementation of advanced care delivery concepts and clinical quality measure (CQM) reporting.

- Voluntary certification program.
- Primary care providers/ clinics.
- Several organizations offer certification.
- Focuses on health transformation toward prevention and outcome improvement.
- Certification can qualify providers for value-based contracts from payers.

NCQA PCMH Measures
(support chronic disease management)

- Controlling high blood pressure.
- Statin therapy for prevention/ treatment of CVD.
- Diabetes A1c - poor control.
- Cancer screening.
- Influenza immunization.
- Tobacco screening and cessation counseling.
- Preventive care and screening BMI.
- Weight assessment and counseling for nutrition and physical activity.
- BMI screening and follow-up plan.
- Closing the referral loop.

NQCA: PCMH Custom Measures
(support chronic disease management)

- Nutrition and physical activity consultation.
- Asthma controller medications.
- Influenza prevention in patients with asthma.
- Asthma control testing.
- Asthma self-management.

Quality Program: Outpatient Provider Participation Required

Clinic Type	QPP-APM	QPP-MIPS	UDS	PCMH
Medicare Fee-for-Service (FSS)	*Yes	*Yes	No	Voluntary
Federally Qualified Health Center (FQHC)	No	No	Yes	Voluntary
Rural Health Clinic (RHCs)	*Yes	*Yes	No	Voluntary

*Required if clinic/provider meets eligibility requirements.

Other Programs

- Quality contracts with commercial payers.
- Internal initiatives and goals.
- Funded projects.
- Healthy Hawaii Strategic Plan (HHSP 2030).
- Hawaii Physical Activity and Nutrition Plan (PAN 2030).
- Hawaii Tobacco Prevention & Control Plan (TPC 2030).

Hospitals

Inpatient Quality Reporting Programs

- Centers for Medicare & Medicaid Services (CMS).
  - Inpatient Quality Reporting Program (IQR)
  - Promoting Interoperability Program (PI).
- Health Resources and Services Administration (HRSA).
  - Medicare Rural Hospital Flexiblity Program (FLEX)

CMS – Inpatient Quality Reporting Program (IQR)

- Required for eligible PPS hospitals
- **Objective:** Provides data transparency for consumers and encourages quality improvement
  - National Healthcare Safety Network (NHSN) measures
  - Claims-based measures
  - Chart abstracted measures
  - eCQMs
  - Process/structural measures
  - Patient experience of care survey measure (HCAHPS).

Inpatient Quality Reporting

- Data collected under the hospital IQR program is publicly available to consumers (Care Compare).
- Data from selected measures are also used under the value-based purchasing programs to reward providers for the quality of care they provide.
- Reported data may apply to other quality reporting programs

CMS - Medicare PI Program

- Required for eligible hospitals and CAHs.
- Used to be called the EHR incentive program/meaningful use.
- **Objective:** to help hospitals implement, utilize and share data via health information technology.
  - Advancement of certified electronic health record technology (CEHRT) functionality.
  - Burden reduction.
  - Advance interoperability.
  - Improving patient access to health information.

CMS – Medicare Promoting Interoperability (PI) Program

Objectives

Protect Patient Information

Electronic Clinical Quality Measures (eCQMS)

Using CEHRT

HRSA – Rural Hospital Flexibility Program

- Available funding for Critical Access Hospitals through State Offices of Rural Health
- **Objective:** Improve quality and access to hospital-based services for rural communities.
  - Medicare Beneficiary Quality Improvement Project (MBQIP)
    - Patient safety
    - Outpatient care
    - Patient Engagement
    - Care Transitions
  - Reporting via the National Healthcare Safety Network (NHSN)and other programs

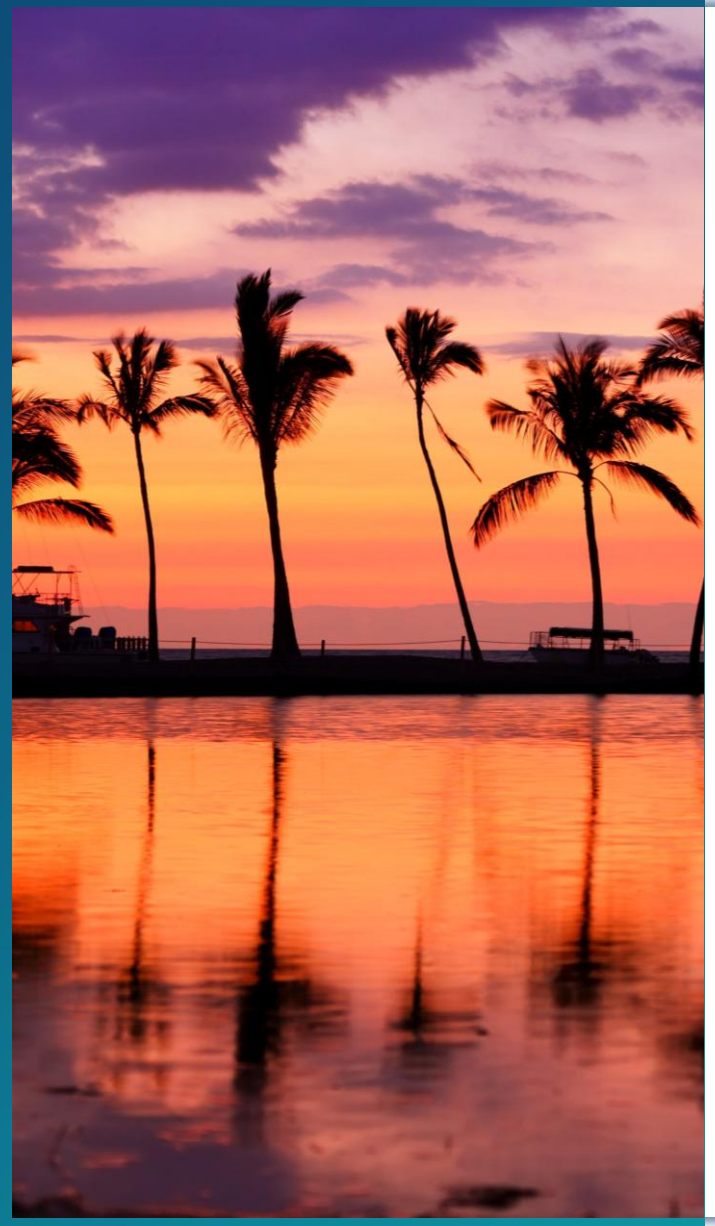
Other Hospital Programs

- CAHs – Conditions of participation.
- PPS/CAH – Joint commission accreditation.

Program – Hospital Participation Requirements

- Inpatient quality reporting (IQR).
- Medicare beneficiary quality improvement project (MBQIP).
- Promoting interoperability (PI).
- Conditions of Participation (CoPs).

Hospital Type	IQR	MBQIP	PI	CoPs	Joint Commission
Prospective Payment Systems (PPS)	Yes	No	*Yes	No	Voluntary
Critical Access Hospital (CAH)	Voluntary	*Yes	*Yes	Yes	Voluntary



Other Programs

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Most Important to Remember

- **Requirements are changing all the time.**
- Data gathering and reporting is getting more complex.
- Not all requirements are tied to payment.
- Best motivation for recruitment of facilities is when you can:
  1. Tie your requests to requirements that affect payment/revenue.
  2. Create projects that improve the measures they are required to report.
  3. Strive to help improve efficiency or capacity and reduce burden.

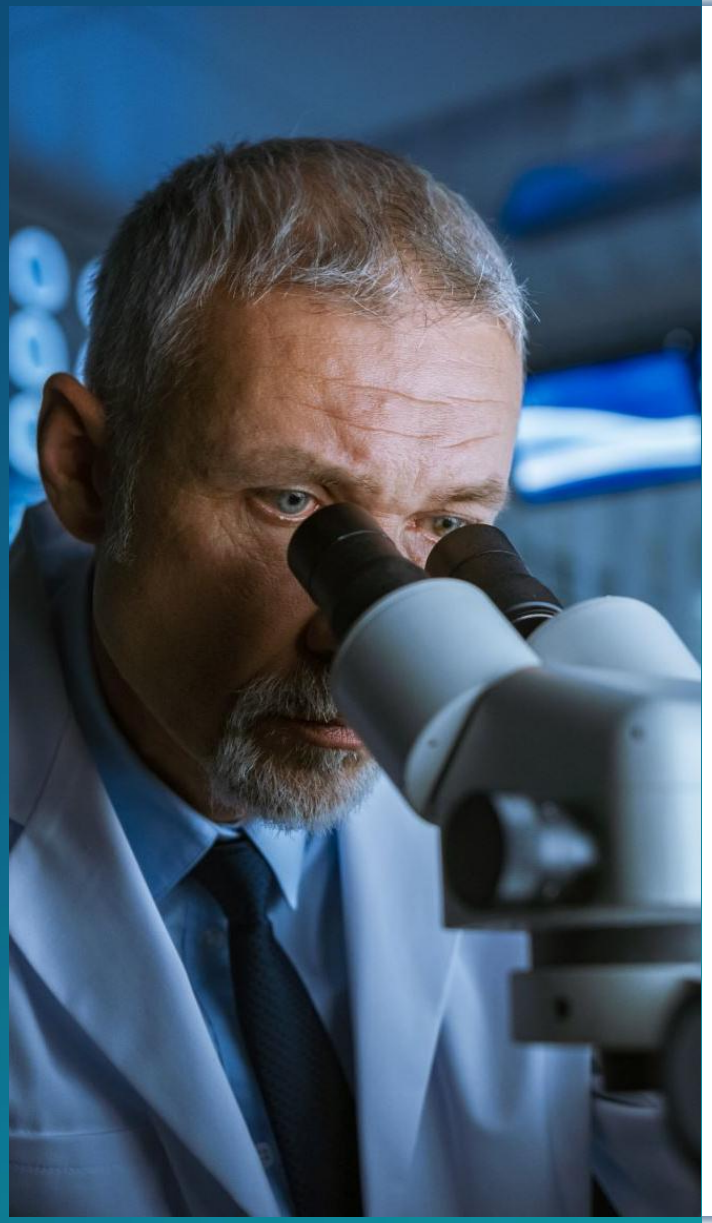
Health System/Provider Engagement

Strategies and Approaches

Mountain Pacific

Increase Our Awareness: General

- Learn quality program requirements and how they might align.
- Know our population, demographics, social needs, cultural diversity, etc.
- Understand and align with the goals of the HI 2030 plans and the organizations working on them.
- Learn what resources, education/training and programs are available that might help support providers, patients and programs.
- Research solutions, innovative alignment and approaches.



Increase Our Awareness: Specific

- Quality reporting programs health systems are participating in.
- Quality measures being focused on.
- Internal initiatives/mission of the organization.
- If social drivers of health (SDOH) screening is used.
- Health system priorities and “pain points.”
- Help providers feel they and their patients might need.

Adjust Approach

- Adjust based on the system's reporting requirements and "pain points."
- Help providers with their problems first.
- Come to recruitment through other avenues/activities.
- Find ways to contribute to improving measures needed for payment models or other priorities.

Align Initiatives and Activities

- Look beyond our program aims for alignment with provider requirements.
- Find ways to align work/services to support or advance their goals.
- Align with services they are offering.
- Identify the resources available to support work and/or address population needs.
- Partner with community organizations to maximize impact.
  - HHSP 2030 plans

Provide Support and Add Value

- Provide “value-added” services – be a problem solver.
- Create or help maintain a community resource guide or provide knowledge on available resources for all needs.
- Connect providers with needed resources.
- Support or provide patient navigation services or referral follow-up.
- Help patients check eligibility and/or sign-up for programs.

Adding Value

- **Support (or expand) existing services** or team-based care approaches.
- **Expand the project** beyond the initial goal (e.g., take DM A1c project and include screening for chronic kidney disease).
- **Provide PDSA worksheets** and other documentation for providers to use for quality program documentation on improvement activities.

Adding More Value

- **Provide suggestions** on what other organizations may be doing, **help connect providers/staff** on sharing best practices.
- **Provide support/technical assistance** for advancing health information technology (HIT), use of plan-do-study-act (PDSA) model for improvement, data tracking and analysis, ideas for improvement, etc.
- **Make meetings, meeting notes and follow up as efficient as possible** and perform research or follow-up for them when possible.

Discussion

What are some things we could do to:

- Adjust our approaches to support health care and other providers.
- Align our program aims with other initiatives.
- Provide support to providers/clinics that help address their barriers to engaging with our programs.

Actions

1

Ask about the health system/ provider's requirements and needs – know their priorities.

2

Know what resources are available locally, regionally and nationally.

3

Be a problem solver – remove or reduce obstacles to allow for greater engagement from providers.

Thank You

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