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Improving Outcomes, Driving Value:
Using HIE Data in Value-Based Payment and Electronic Clinical Quality Measures

October 25, 2022

Objectives

- Learn how organizations are adapting to the value-based payment environment in order to be successful.
- Understand how organizations are using population health, utilization and other data to improve quality and earn value-based performance measures.
- Understand challenges and pain points providers experience in moving from volume to value.

Value-Based Programs

- Reward healthcare providers with incentive payments for the quality of care provided
- Support:
  - Improved individual outcomes
  - Improved population outcomes
  - Reduced cost of care

Examples

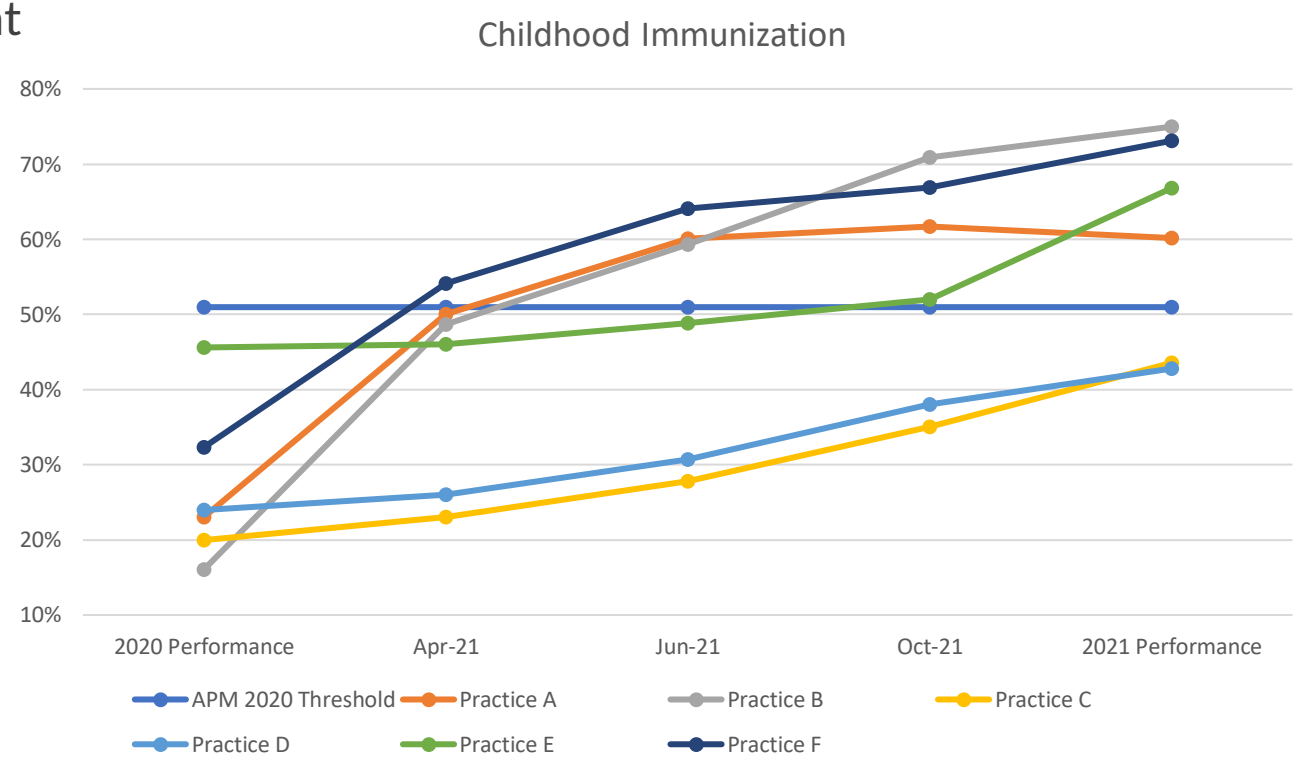
- Programs
  - Quality Payment Program
  - Alternative Payment Models
  - Primary Care First (CO)
    - Comprehensive Primary Care Initiative (CO)
  - Differential Adjusted Payment (DAP) (AZ)
  - Targeted Investment (TI) (AZ)
  - Hospital Transformation Program (HTP)
- Contracts
  - Accountable Care Organizations
  - Commercial contracts

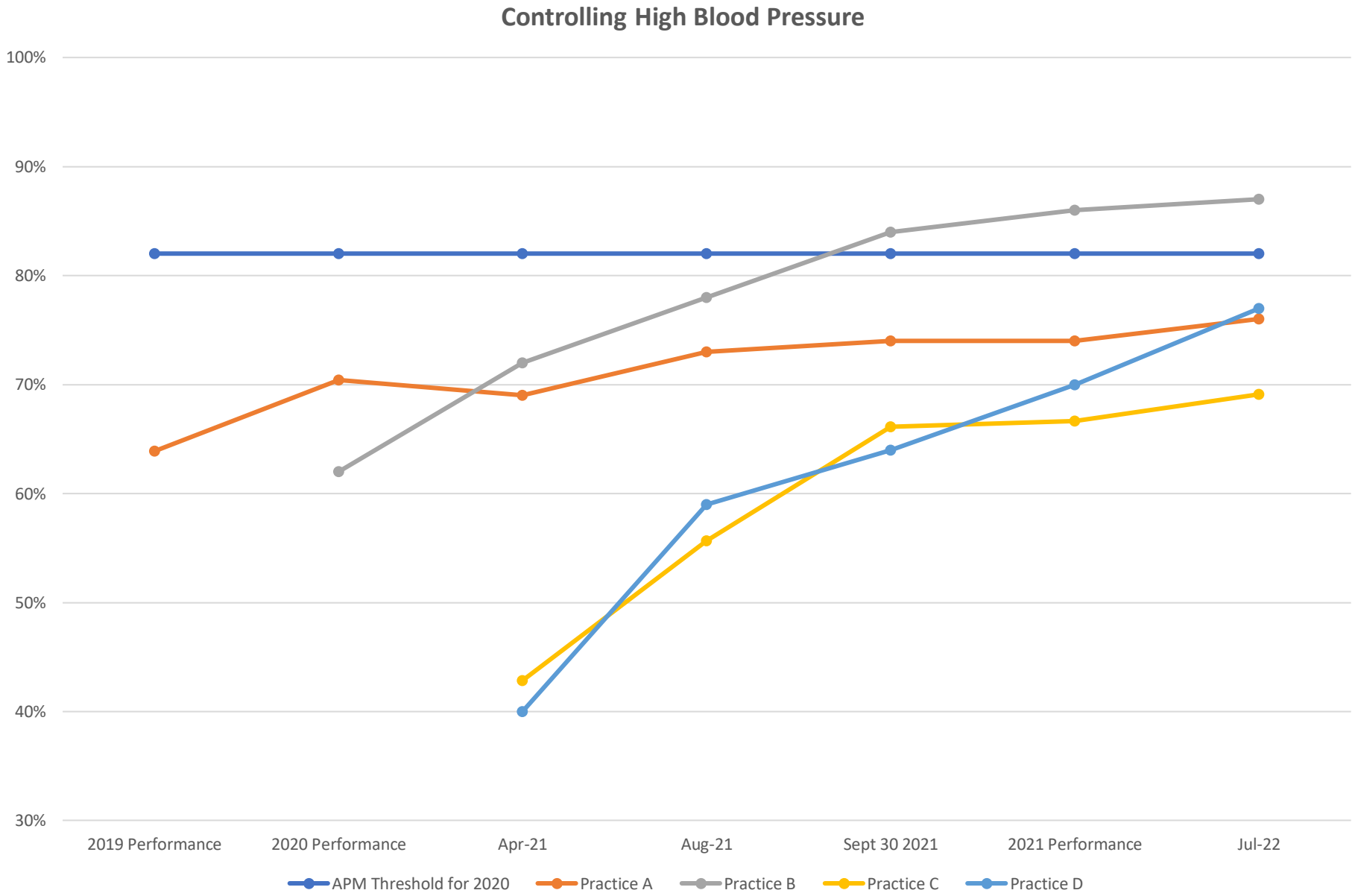
Components of Value-Based Programs/Contracts

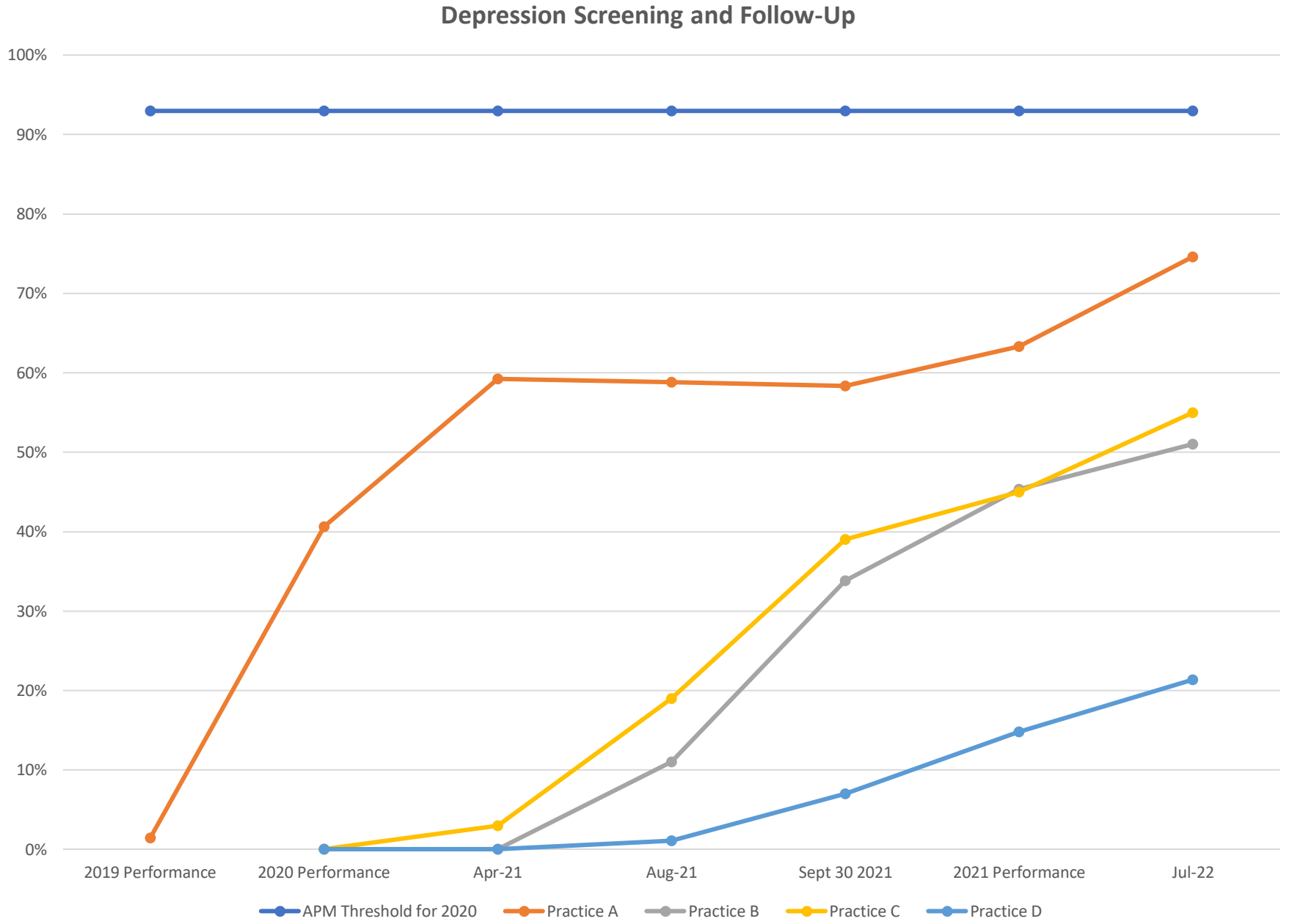
- Quality of care
  - Clinical quality measurement
  - Claims measurement
- Utilization of data
- Milestone Activities
  - Utilization of PDMP
  - Empanelment
  - Quality Improvement Efforts
- Risk coding

Medicaid APM Program

- electronic Clinical Quality Measures (eCQM)
  - Utilize Continuity of Care Documents received by the HIE
  - Technical Assistance
    - Supporting Quality Improvement




Controlling High Blood Pressure
100%
90%
80%
70%
60%
50%
40%
30%
2019 Performance
2020 Performance
Apr-21
Aug-21
Sept 30 2021
2021 Performance
Jul-22
APM Threshold for 2020
Practice A
Practice B
Practice C
Practice D


Depression Screening and Follow-Up
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
2019 Performance
2020 Performance
Apr-21
Aug-21
Sept 30 2021
2021 Performance
Jul-22
APM Threshold for 2020
Practice A
Practice B
Practice C
Practice D

Contexture Support

- Value of Health Information Exchange Data
  - Patient Portal
  - Notifications
- Certified CMS Qualified Registry
  - Reporting on clinical quality measures
    - Primary Care First
    - Quality Payment Program (QPP)
- Consulting Services
  - QPP Coaching
  - Quality Improvement (QI) Coaching
  - Risk Coding
  - eCQM Support

Panelists

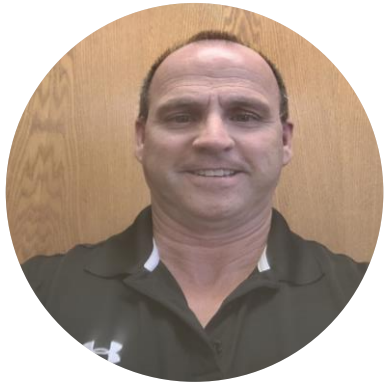
Lauren Girard

VP, Quality Improvement & Business Line Management
Contexture

Moderator

Tiffany Mahaso

Director of Practice Management
Rocky Vista Health center



Rich Lane

Practice Manager
Champions Family Medical

Audrey Reich Loy, LCSW, LAC

Director, Program Operations
San Luis Valley Health Regional Medical Center
Alamosa, CO

Data Management = Improved Outcomes

- External Data
  - EMR Data
  - VB Contract Data; Contexture Data; Claims
  - Care Management Data
- Data Management
  - Daily Census
  - BCA
  - Registries
    - Pop Health: Risk, CQM, Utilization
  - Access
  - Manual Tracking
- Response to Data
  - Measure Dashboards – Build, Test, Validate, Monitor, PDSA, Perform
  - Care Management activities/Targeted outreach
  - Team Planned Care/Pre-Visit Planning
  - Campaigns
  - PDSAs

Our Programs
(past/present/future):

- RAE Delegation for CC
- RAE KPIs
- CPC+
- RHCs
- APMs-Medicaid
- Humana, BCBS
- MIPs
- REACH ACO
- Provider Variable Pay

San Luis Valley HEALTH

Champions Family Medical

Our Road Map in Transitioning From Fee for Service to Value-Based Programs

ACO – UC Health – Started in October 2017

- Commercial and Medicare Advantage
- Clinical Reports – Open Gap Opportunities, Avoidable Emergency Room Visits, Annual Physicals, Claims Data
- Monthly Meetings
- Care Coordination – Emergency Room and Inpatient Admission Follow up
- Generic Vs Name Brand Prescription Dispensing Rate
- MIPS to MSSP – Transitioning to MSSP in 2023

Beacon Health – RAE 4: Colorado Medicaid – Started in June 2018

- Care Coordination – Emergency Room and Inpatient Admission Follow up
- KPI's
- Practice Transformation Incentive Programs – Patient Surveys, Diabetes Control, Employee Recognition Programs
- Monthly Meetings – Quarterly Data Reporting – End of Year Wrap up

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Family Medical

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Our Road Map in Transitioning From Fee for Service to Value-Based Programs

APM1: Colorado Medicaid – Started in January 2020

- eCQM's, Claims Data, Structural Measures
- Met and Exceeded the Requirements for 2020 and 2021

Innovation Support Project – Started in April 2020

- CORHIO now Contexture – Includes Partners With Beacon Health and Pueblo Department of Public Health
- Regional Health Connector Support to Provide Community Linkages to Support Patient Needs
- Support APM1 Reporting Requirements – eCQM's, Claims Data, Structural Measures
- Monthly Meetings – Quarterly Data Reporting – End of Year Final Submission
- Practice Transformation Milestones to Align With Other Program Goals

APM2: Colorado Medicaid – Started in January 2022

- PMPM Prospective Payment Model in Addition to fee for Service
- Gain-sharing on Chronic Conditions

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Rocky Vista Health Center

- The Rocky Vista Health Center is an Internal Medicine residency clinic in Parker, CO. The health center is comprised of:
  - 52 internal medicine resident physicians
  - 3 osteopathic resident physicians
  - Several subspecialist physicians including Podiatry, Nephrology, and Behavioral Health
  - Total of 72 physicians in our practice

- Our residents work at Skyridge, Aurora South, and Presbyterian St. Luke's hospitals

Rocky Vista Health Center

Project efforts that support the clinic and various patient populations quality metrics:

- Colorado Care Partners is an ACO with value-based care contracts diabetic eye exams, annual wellness exams, breast cancer screening)
- Practice Health- an IPA, independent practice association, and they hold our fee for service contracts
- Colorado Access- comprised of our Medicaid population in the health center. We use the state's Alternative Payment Model and track structural measures.
- ISP- August 2021
  - Goal- improve the quality of care while enhancing the opportunity to succeed in new payment models, including Medicaid's Alternative Payment Model (APM) for Primary Care.

Rocky Vista Health Center

- Tools we utilize to track quality and structural metrics:
  - EMR- Athena Health
    - Data can be pulled from various tabs such as the Quality tab, eCQM, program enrollment
  - Practice Navigators and Facilitators
    - The previously listed programs we are enrolled in assign us an individual or a team who helps us pull the data, reconcile any inconsistencies, and review our metrics on a monthly basis
      - CCP/PH has an interface that sends us notifications through Contexture with up-to-date patient information such as hospitalizations, lab results, and stays at other partnered hospitals

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How does the HIE support your various programs and supporting the quintuple aim?

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What would all of you say are the top 1 to 2 challenges in implementing value-based contracts?

How does the HIE support you through these challenges?

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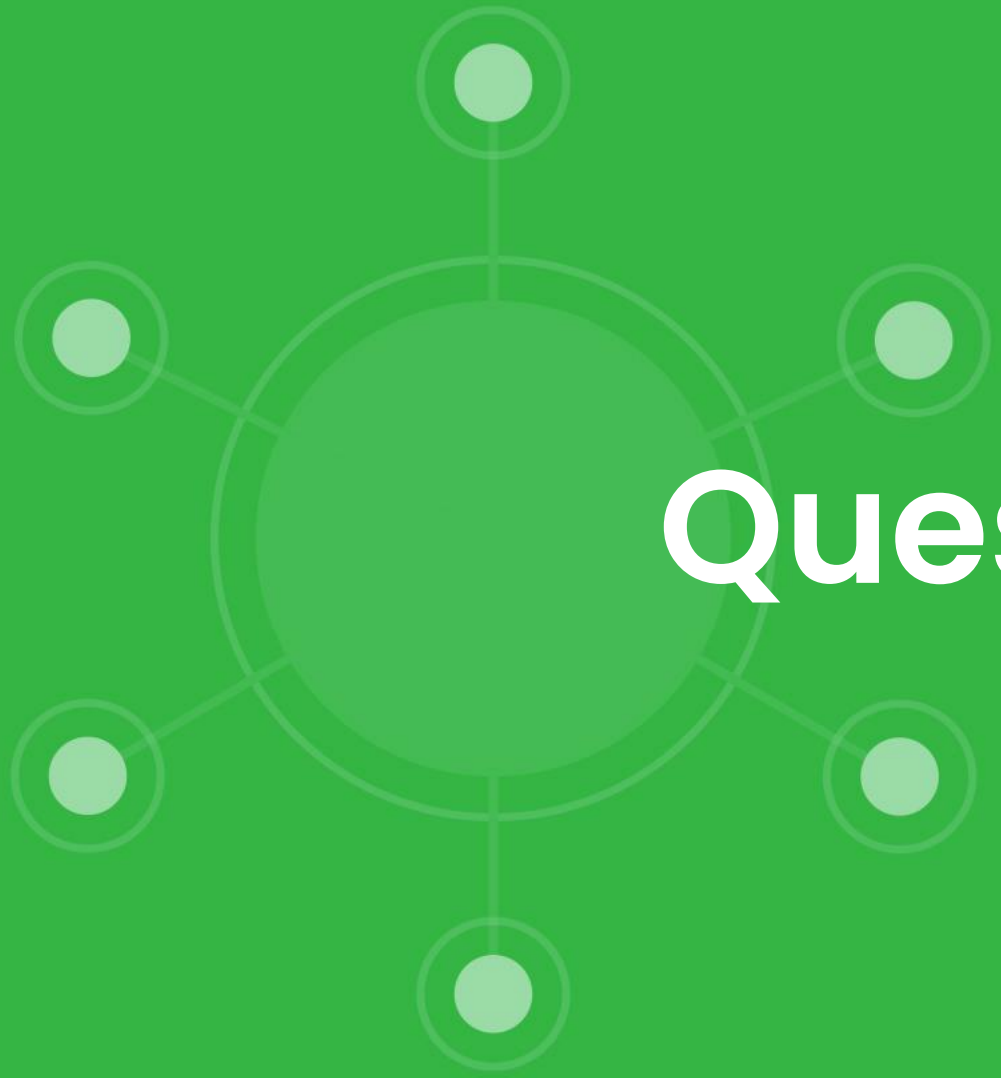
What changes in value-based contracts do you anticipate in the coming years, how can the HIE serve you now and in the future to meet those needs?



Questions