BHNNY PPS Phase Three Pay for Performance Measures

Performance Improvement Resource Guide

Better Health Northern New York (BHNNY) PPS is committed to supporting our partners in improving the quality and cost of care. The focus to date has been on improving processes, understanding the patient population and practice transformation. Our next focus is to understand the impact of this work on outcomes of care.

This resource guide provides considerations that practices can evaluate. Opportunities to enhance workflows, leverage technology and partner with external resources can lead to better care.

Best Practices for all Measures

The Importance of Coding and Documentation

- Data largely relies on documentation/claims submitted by the provider. Our work with practices has demonstrated that the data practices are capturing within their own EMR is not necessarily reflected in their billing and coding submitted to payers. It is important that the diagnosis codes and clinical documentation that practices submit are consistent and accurately reflect the patient's condition. Submitting a claim with the wrong diagnosis code may inadvertently indicate the necessity for diagnostic testing and/or medications/treatment plan. If those tests are not performed this may indicate a gap in care according to the way the measure is scored. Practices should have a "checks and balances" system within their practice for their coding, documentation and treatment plans.

Working with Health Plans and PPS

- Work with your payers and PPS partners to determine if they offer any services to help improve your measures. Options may include a population health management system that identifies the gaps in care, automated reminders for services, patient incentives for preventive services, printed resources or materials to distribute to patients, education for providers including online videos or in-person conferences, or additional funding for coordination activities. Education may also be available through mailings, email, newsletters, telephonic outreach, and online tools and resources.

Practice Workflows and Policies

- One consistent method for improving quality outcomes is creating a documented process workflow or approved policy. This should include which team members are responsible, how often the action should occur, the steps needed to perform the action and any follow up and monitoring required to ensure the policy is adhered to. Staff should be part of the process and used as subject matter experts to help craft workflows. Many of the measures referenced need

consistent workflows where all members on the team understand their role and perform it in the guided manner of the policy. Variation is where breakdown develops, hence impacting the outcomes. Leadership should monitor policy adherence and amend policies if workflows change. Implementing a pilot program of policies are a great way to slowly introduce standardization and "buy in." Once successful, policies can then be rolled out to the entire site.

Training and Communication

- Once a policy is developed, training and communication is needed to guarantee all staff is on the same page and understand their accountabilities and deliverables. The team is more likely to adhere to a policy if they are on board with the goals and feel like they are part of the change. Keep them in the loop through communications and meetings is key to successful change management and achieving goals. Training and communication can be in the form of in-person meetings, emails, etc.

Technology as a Partner

- Utilizing the functionalities within the EMR and other technologies employed by the site is critical to the success of measure managements and improvement. There are many tools available within technological platforms that may be underutilized due to a lack of training or time, or perhaps because the additional tools were not installed/purchased. Sites should lean on technology to assist with practice workflows as it will create efficiencies and allow for information to be obtained and analyzed with ease. Some areas to consider:

1. Registries: Use registries to run reports of patients with chronic conditions, medications, ages, sex, demographic considerations, and last visit. These reports will easily help to identify where the gaps in care lie. Also explore if these reports can be set to run on a schedule or if a manual effort will be required each time. Either way, registries are still a very valuable tool to target specific patient populations.
2. Campaigns/Proactive Outreach: Explore if the system allows for emails/ automated calls to be made to patients who need services based on measures prominent in your practice regarding visits, follow up, immunizations, tests and screenings.
3. CQM Reports: Analyze data base on measures pertinent to the practice in given time frames. Seek to improve and remeasure after changes were implemented in the practice.
4. Decision Support: Implement alerts and clinical care evidence-based guidelines to assist with treating patients at the point of care.
5. Flags or Alarms: Identify patients for a certain reason such as condition, social determinant of health, or a gap in care that is visible when the patient presents.
6. Portals/Secure Messaging: Another way to communicate with patients and increase accessibility to your practice.
7. RHIO: A valuable source of information to utilize, the RHIO keeps sites aware of patient pathways throughout the medical neighborhood
8. Structured Data and Templates: Having data that is in reportable fields versus "free text" makes it easier to run reports and obtain real time information quickly. It also allows for more consistency in practice documentation.

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Quality Improvement Activities

- Practices should engage in Plan Do Study Act (PDSA) cycles to impact change on measures that are pertinent to their patient panels. PDSA's can be short-term or long-term and ask practices to 1) analyze data and patient needs 2) set goals based on benchmarks 3) put action into place to affect change in the form of workflow adjustments, education, and technology embracement 4) remeasure and evaluate outcomes to determine next steps. Care team members should all play an active role in performance improvement activities.

Standing Orders

- Standing orders can be an excellent way to stream-line interventions and ensure they are completed consistently. Examples could be immunizations or orders for labs and imaging. It also allows for accountabilities throughout the care team to work at the top of their license and training.

Lab and Imaging Tracking

- For all lab or imaging testing develop a procedure to follow up on outstanding orders. This should include identifying orders that have been sent out and noting when would be appropriate to follow up with the patient or lab/imaging facility to determine why you have not received the results back. Document these efforts until the loop is closed.

Referral Management/Tracking

- Consistent with lab/test tracking above, it is critical to follow up and "close the loop" on specialist visits to which you have referred patients.

Care Transitions

- Follow up with patients who have had visits in other facilities such as urgent-center centers, hospitals or rehab facilities. Also, implement a system that alerts sites to admissions and discharges.

Proactive Patient Outreach

- Establish a documented process where a team member(s) is identified to run regularly scheduled reports for the practice. This team member should outreach to patients who are overdue for wellness visits, preventive services or disease management services. Each of the measures here can and should utilize gap-based reports, including your health plan non-adherent lists and EMR functionality, to find patients who are missing these services.

Social Determinant and Vulnerability Screenings

- Determine through social determinant screenings if your patients have barriers to care such as lack of transportation or inability to pay for medications. Work with your local places of worship and community-based organizations to see if existing programs may assist patients and offer an opportunity to address barriers. In addition, stay apprised of opportunities and programs that reduce costs for prescription drugs and durable medical equipment to give you patients opportunities to afford these therapies.
- Offer culturally and linguistically appropriate educational materials and support services (such as interpreters) to persons of ethnic and racial minorities, as well as other underserved groups

such as the elderly, immigrants, and people with disabilities. Make sure you consider patients' functional and health literacy levels in all materials and conversations.

Patient Navigation/ Care Coordination and Care Management

- When feasible, use a patient navigator or care coordinator or other assigned staff team member to facilitate making appointments outside of your office. When not possible, provide lists of local resources relative to care needed. Some of these conditions may warrant enrollment of the patient into a care management program.

Celebrate and Study Successes

- When a practice is succeeding in achieving their goals, it is important to recognize those achievements, celebrate them, and then research the mechanics behind them. To learn how to mimic patterns in a similarly structured office (same specialty, EMR, size) who may not be meeting desired outcomes, it is best to learn from a subject matter expert. Sometimes it is even more powerful if representation of the same title (doctor to doctor, office manager to office manager) discuss best practices, obstacles and solutions, etc... for both practices to achieve desired outcomes.

Strategies to Improve Measure Domains

BHNNY Phase III performance measures are categorized by one or more of the following three measure domains:

1. **Improving Access to Care**
2. **Improving Efficiency of Care**
3. **Improving Effectiveness of Care**

Each measure has a detailed description reflecting the expected outcome. The measures apply to different settings of care. Similarities in practice workflow considerations may overlap across the measures associated with the domain.

Within each domain, specific focus may include preventative/screening, chronic disease management, care transitions and integration of behavioral health.

Understanding the numerator and denominator description provides clarity to the parameters applied to define the patient population. The patient population associated with the measure may have specificity related to age, time frames and conditions.

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Improving Access to Care

Practice Workflow:

- Policy to be developed on Patient-Centered Access within the office:
  - Hours
  - Appointment scheduling
  - Alternative appointments (if applicable)
  - Patient materials
  - Monitoring/reports/ownership
- Policy to be developed on Clinical Advice within the office:
  - How to contact office 24/7
    - Telephone
    - Portal/secure messaging
  - Monitoring/ownership
  - Documentation
- Ensure hours are posted/updated on:
  - Door
  - Exam rooms
  - Website
  - Patient facing materials
- Follow up same day with "no-shows"
- Perform daily huddles and pre-visit prep to discuss patients who are scheduled for the day, including frequent "no shows," and have chronic conditions that need to be managed. Also, identify if these patients have social determinants needs and if/ how the practice can assist
- Systematic and proactive outreach to be made to patients who are due for visits/services. This can be in the form of telephone calls, letters, e-messages or texts. Documentation of this outreach should be created and maintained.
- Systematic and proactive report running/obtaining of "frequent flyers" to the ED
- Conduct staff training and education so all are informed, and consistent practices are in place
- Consider RHIO connectivity and additional training to use the information obtained from RHIO as a technical partner within your practice

- **Patient Engagement:**
  - Patient orientation conducted/materials distributed
  - Community resources/support groups should be available and offered/arranged for patients who need social, financial/insurance, condition, transportation, meal, exercise, etc. assistance.
  - Providers should discuss the following with patients:
    - The importance of follow up appointments
    - The value of preventative visits/services
    - The outcomes if preventative and or follow up appointments are not kept

- How to reach the practice 24/7
- Provide a guide/shared decision-making tool on when to utilize:
  - ED
  - Urgent Care
  - Clinical Advice/primary care office
- Review preventative care needs/schedule based on age/condition/sex
- Review follow up care needs based on condition
- Staff to assist patients prior to leaving office with scheduling recommended visits

- Suggest scheduling reminders via smartphone to take medication, or download a free app on smartphone, such as Medisafe
- Provide written instructions and suggest placing them in view on refrigerator (ie. a list of upcoming appointments)
- Patient to understand the cost associated with ED v. PCP visit
- Patient to understand wait times with ED v. PCP
- Patient survey to evaluate access opportunities

- **Provider Engagement:**
  - Use motivational inclusive conversation techniques to communicate with patients and caregivers in a form that is culturally and linguistically appropriate and aligned with their level of understanding
  - Consider care planning around follow up and preventative care and ensure the patient can "teach-back" the importance of keeping visits, when their next visits are scheduled and what they are for

- **Health Plan Partnership:**
  - Identify if health plans have a provider portal to assess and retrieve non-adherent/ high-utilizers lists
  - Receive alerts of admissions/discharges and act upon them
  - Check if your health plans currently perform patient engagement activities, such as reminder letters, calls to non- adherent members.
  - Find out what services your health plans offer patients for chronic and preventative health: disease management, health coaching, and stress management, recommended visit schedules etc.
  - Incentive programs for patients who are adherent based on conditions

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Improving Effectiveness of Care

Medication Management

- Policy to be developed on Medication Management within the office:
  - Who/owners
  - Process (where, when, documentation and how)
  - Frequency
  - Monitoring
- Run lists from registries and/or obtain lists from insurance companies of patients who are on medications in question
  - Practices should flag these patients within the system and make these patients easily identifiable
- Perform daily huddles to discuss patients that are scheduled for the day, what their needs are, and what conversations or support needs to be available based on the medication they have been prescribed
- Conduct pre-visit planning activities by identifying patients on medications that need follow up. Prior to a patient's follow up visit, contact the patient to ensure that the script was filled and the patient is actively taking as prescribed. Document outcome of call and review at daily huddle a prepared action plan for the office at time of visit
  - Utilize a prescription database to verify if a medication was picked up/filled
- Systematic and proactive outreach to be made to patients who are prescribed applicable medications for pertinent follow up. This can be in the form of telephone calls, letters, e-messages or texts. Documentation of this outreach should be created and maintained
- Conduct staff training and education so all are informed, and consistent practices are in place

Behavioral Health Management

- **Patient Engagement:**
  - Pamphlets from pertinent resources regarding mental and behavioral health should be kept in your office waiting room/exam rooms. Sources available are from the ADAA, IMH, NIMH, APA, and DOH
  - Community resources/support groups should be available and offered/arranged to patients who need social, financial, condition, transportation, meal, exercise, etc. assistance.
  - Providers should discuss the following with patients:
    - Expectations of how long to wait regarding the effectiveness of medications- most anti-depressants take 1-6 weeks to work before the patient starts to feel better (to avoid discouraged patients)
    - Sleep and appetite improve first while improvement in mood, energy and negative thinking may take longer
    - How long he or she needs to be on the medication

    - Risks of discontinuing the mediation, and its association with higher recurrence of psychotic episode or depression/anxiety
    - The possible side effects, and what the patient should do if he or she experiences any
    - Stress the importance of continuing medication, even if he or she is feeling better
    - How to get in touch with the office in case of questions or concerns via 24/7 phone line and/ or secure messaging
  - Follow up visits should occur in three to six weeks to reassess symptoms and see if changes need to be made to medication type(s) or dosage(s)
    - Staff to assist patients prior to leaving office with scheduling
  - Suggest scheduling reminders via smartphone to take medication, or download a free app on smartphone, such as Medisafe.
  - Suggest taking medication at the same time as brushing teeth or eating breakfast:
    - Provide written instructions to support educational messages and suggest placing them in view on refrigerator
    - Give logs/diaries to patients to document when medication was taken
    - Logs/diaries can also be used for patient to document how they were feeling each day or any ebbs or flows in their behavior daily

- **Provider Engagement:**
  - Use shared decision-making tools for depression treatment to ensure the path taken for both medication and behavior therapies are within the patient preferences and meet the stage of change the patient is willing to make. Samples can be found at websites like mayo clinic and SAMHSA
  - Use motivational inclusive conversation techniques to communicate with patients and caregivers in a form that is culturally and linguistically appropriate and aligned with their level of understanding
  - Consider care planning around medication management and document at relevant visits: medication response, barriers patients are having to taking medications, their overall level of understanding of how to take the medications and what they are for, and why it is important to continue as prescribed
  - Provide patients brochures/information from EMR data base, pharmaceutical resources, or other systems i.e. Up-to-Date.
  - Discuss:
    - For mild or minimal depression, recommended treatment includes education, behavioral activation (exercise, social support, increase fun and stress relieving activities), self-management, and healthy lifestyle (healthy eating, limit alcohol, etc.);
    - For moderate depression, the recommended treatment includes all the options for mild/minimal depression as well as the added treatment of psychotherapy and/or medication;
    - For severe major depression, recommended treatment includes all the options for mild/minimal/moderate depression as well as BOTH psychotherapy and medication.

  - Consider educational programs offered through PPS or hospital affiliations on primary care and treatment of behavioral health conditions

- **Health Plan Partnership:**
  - Identify if health plans have a provider portal to assess and retrieve non-adherent/ high-utilizers lists
  - Check with health plan to obtain monthly pharmacy data for a list of patients on anti-depressants/antipsychotics and their last fill date.
  - Check if your health plans currently perform patient engagement activities, such as reminder letters, calls to non-adherent members.
  - Find out what services your health plans offer patients for behavioral health: disease management, health coaching, stress management, etc.
  - Obtain listing of BH service providers from your plans and community organizations.

Improving Efficiency of Care

- **Practice Workflow:**
  - Policy to be developed on Care Management and self-support within the office:
    - ID conditions
    - Flagging patients
    - Monitoring/ownership
    - Care planning
    - Community resources/education/tools
  - Policy to be developed on Evidence-Based Guidelines within the office:
    - Which conditions are meaningful to the practice
    - Which guidelines will be employed
    - Flagging and technology support
    - Point of care actions/documentation
    - Monitoring/ownership
      - Evaluation over time
  - Policy to be developed on Gaps in Care within the office:
    - What conditions, screenings, visits are meaningful to our panel
      - Evaluation over time
    - Gathering patient lists
      - From what sources
    - Contacting patients
      - Electronically, telephonically, letters
    - Frequency
    - Ownership and monitoring
  - Policy to be developed on Care Coordination within the office:
    - Closing the loop processes on:
      - Tests
      - Referrals
      - Transitions of care

        - Ownership and monitoring
        - Documentation
    - Perform daily huddles and pre-visit planning to discuss patients that are scheduled for the day with chronic conditions and or care transitions that need to be managed. Also, identify if these patients have social determinants needs and if/ how can the practice assist
    - Systematic and proactive outreach to be made to patients who are due for visits/services. This can be in the form of telephone calls, letters, e-messages or texts. Documentation of this outreach should be created and maintained
    - Systematic and proactive report running/obtaining of "frequent flyers" to the ED
    - Conduct staff training and education so all are informed, and consistent practices are in place
    - Conduct screening assessments on:
        - Behavioral and substance abuse
        - Social Determinants of Health
    - Perform close the loop activities and document follow up items

- **Patient Engagement:**
    - Assign a care manager (or applicable care team member) to assist with care coordination
    - Community resources/support groups should be available and offered/arranged for patients who need social, financial/insurance, condition, transportation, meal, exercise, etc. assistance.
    - Education in the form of conversation, pamphlets, shared decision aids
    - Providers should discuss the following with patients:
        - The importance of follow up appointments
        - How to reach the practice 24/7
        - Review follow up care needs based on condition
        - Staff to assist patients prior to leaving office with scheduling recommended visits
    - Suggest scheduling reminders via smartphone to take medication, or download a free app on smartphone, such as Medisafe.
    - Provide written instructions and suggest placing them in view on refrigerator for example of appointments

- **Provider Engagement:**
    - Use motivational inclusive conversation techniques to communicate with patients and caregivers in a form that is culturally and linguistically appropriate and aligned with their level of understanding
    - Consider care planning around follow up and preventative care and ensure the patient can "teach-back" the importance of keeping visits, when their next visits are scheduled and what they are for. Care planning needs to include:
        - Barriers and solutions
        - Preferences
        - Goals
        - Self-management tools and direction

  - Provide a copy of the care plan to the patient
  - Perform EBDS at the point of care
  - Use shared decision aids when treating patients

- **Health Plan Partnership:**
  - Identify if health plans have a provider portal to assess and retrieve non-adherent/ high-utilizers lists
  - Check if your health plans currently perform patient engagement activities, such as reminder letters, calls to non-adherent members.
  - Do the health plans have patient lists by disease?
  - Find out what services your health plans offer patients for chronic and preventative health: disease management, health coaching, and stress management, recommended visit schedules etc.
  - Incentive programs for patients who are adherent, based on conditions