Strategies to Care for Special Populations in a Value Based Care Environment

National Hispanic Medical Association 23rd Annual Conference and Hispanic Dental Association

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AGENDA

- About HCD International

- What is Value Based Care?

- Seven Strategies for Success

- Tools and Resources

HCD International

- **HealthCare Dynamics International** (HCDI) is a quality improvement and clinical transformation consulting firm
- Focus on the transformation of clinicians serving vulnerable populations regionally and across the United States
- Collaborate with minority medical associations to provide innovative quality improvement solutions to address health inequities by understanding
    - the socio-economic construct of patients in rural and medically underserved practices
    - the resource constraints of these practices
    - clinician concerns surrounding negative MIPS adjustments for social factors that adversely impact health outcomes
- Address the unique patient, practice and culture characteristics that impact health outcomes and their ability to transform successfully
- Focusing on the economics of equity and population health in a value-based reimbursement environment

MACRA/ Quality Payment Program

The **Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)** is a bipartisan legislation signed into law on April 16, 2015

Quality Payment Program (QPP)

Merit-Based Incentive Payment System (MIPS)

Alternative Payment Models (APMs)

7 **Strategies for Success**

- Person-centered Care Coordination
- Social Determinants of Health
    - Caring For Your Health Social Determinants Indicator Tool
- Use of Electronic Health Record
- Patient Engagement through Wellness Programs
- Chronic Care Management
- Transitional Care Management
- Hierarchical Condition Category (HCC) Coding

Tools and Resources
- MACRA Monday (Every Monday 3:30 – 4:30pm EST)
- Office Hours

1. Care Coordination

PS Please take some time to visit our HCDI TCPI SAN Homepage: http://www.tcpisan.org/

Hispanics population are a large and growing share of the U.S. population

2015:

About 53 million people living in the U.S. are Hispanic, making up **1 in 5** of the population.

2045:

Hispanics are projected to account for **1 in 4** people living in the U.S. by 2045.

2. Social Determinants of Health

Social determinants of health

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Social Determinants of Health Factors

Social Determinant Factors

Clinical Information

CARING FOR YOUR HEALTH

Our office aims to improve care provided to you. Please read each statement and select the best answer that relates to you. Your responses to each of the questions will contribute to our ability to support your care.

Last name

First name

Age

Zip code

Sex
*Choose one

Race
*Choose one

Hispanic/Latino/Spanish origin?
No, Hispanic/Latino/Spanish origin

Is English your primary language?
*Choose one Or Enter Preferred Langu

Job Status
*Choose one

Food Access
*Choose one

Education
*Choose one

Access to Transportation
*Choose one

Have you moved two or more times in the past 12 months?
*Choose one

How often do you feel isolated / lonely from those around you?*
*Choose one

Because of a physical, mental, or emotional condition, are you able to make your doctor's appointments or take your medicines?
*Choose one

How often does anyone including a family member physically or verbally hurt you?
*Choose one

Do you have problems with any of the following where you live?

◯ Bug infestation   ◯ Mold   ◯ Lead Paint or Pipes   ◯ No Heat

◯ Electricity/Gas not working   ◯ Non-working smoke detectors   ◯ Water leaks   ◯ None of the above

Do you need help with any of these day-to-day activities? Answers (Select all that apply):

◯ Bathing   ◯ Preparing meals   ◯ Shopping   ◯ Managing Money   ◯ Paying for prescriptions

Hospital stays in the past 12 months
*Choose one

ER visits in the past year
*Choose one

Number of Medications
*Choose one

Do you have Diabetes?
◯ YES   ◉ NO

DIABETES

Do you know your HbA1c?
*Choose one

Did you have an eye exam within the past 12 months?
*Choose one

Did you have a foot exam by a healthcare provider within the past 12 months?
*Choose one

Do you have any other personal problems with your health? If so, please list them

Leveraging Actionable Data from the CFYH Tool: Z Coding

ICD-10 has greatly expanded the number and specificity of codes. Among those are Z codes that describe supplemental factors related to a healthcare encounter.

- CFYH Tool and Z codes: Z55-Z65- Persons with potential health hazards related to socioeconomic and psychological circumstances:
  - Z55 Problems related to education and literacy
  - Z56 Problems related to employment and unemployment
  - Z57 Occupational exposure to risk factors
  - Z59 Problems related to housing and economic circumstances
  - Z60 Problems related to social environment
  - Z62 Problems related to upbringing
  - Z63 Other problems related to primary support group, including family circumstances
  - Z64 Problems related to certain psychosocial circumstances
  - Z65 Problems related to other psychosocial circumstances

CARING FOR YOUR HEALTH SOCIAL DETERMINANTS INDICATOR TOOL SERVICES

- Website www.tcpisan/resources.org
  - o Review website
  - o Register

- Free Patient-Facing Social Determinant of Health Tool
- Purpose: High No-Shows, High ER Use, Low Quality Scores
- Education and Training
- Workflow Support
- Care Coordination
- Community Resources
- Reporting

3. Use of Electronic Health Record

- Digital technology applications and integrations will have a major impact on value-based care with the new reimbursement program.

- Certified Electronic Health Record Technology (CEHRT) use is at the center of the Quality Payment Program with both MIPS and APMs requiring the use of CEHRT to qualify for positive Medicare reimbursement.

- Technologies integrated with the EHR will help eligible clinicians make better and faster patient diagnoses while also connecting other eligible clinician networks in order to process referrals and sending prescriptions to pharmacies

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4. Annual Wellness Exams for Patients

- One hour per year **extends life and reduces disabilities**.
    - o Increases compliance with preventive care.
    - o Detects emerging chronic conditions.
    - o Detects functional decline.
    - o Detects changes in family/social support.
    - o Detects depression and substance abuse.
    - o Detects vision and hearing loss.
- Appropriate referrals and follow up **reduces progression of diseases and improves outcomes.**

Average billable revenue for 1 hour per year = $225-$400

Value of Wellness Visits for Providers

- **Increases patient compliance** with prevention guidelines.

- **Identifies patients at risk** for developing chronic conditions for early intervention and Care Coordination.

- Addresses and **improves 11 Quality Measures**.

- **Documents all medications** to simplify ongoing medication reconciliation.

- **Documents all co-morbidities** annually for risk adjustment

- **Increases revenue** to support more population health staffing.

- **Increases attribution** of healthy patients to your practice.

- Allows practice to provide billable **Advanced Care Planning** service to patient without copay or deductible if part of wellness visit.

5. Chronic Care Management

- Partnering with patients to improve ability to self-manage their disease
- Patient/family centric; trusting relationships; use of health coaching principles and mutual goal setting
- Creating Care Plan and monitoring progress toward goal achievement and plan of care adherence
- Effective communication with providers and care team around plan of care, access and utilization of services
- Care team support partners that assist with linkage to community resource needs

6. Transitional Care Management

Transitional care management (TCM) includes services provided to a patient with medical and/or psychosocial problems requiring moderate or high-complexity medical decision making. TCM services involve a transition of care from one of the following hospital settings:

- Inpatient acute care hospital
- Inpatient psychiatric hospital
- Long-term care hospital
- Skilled nursing facility
- Inpatient rehabilitation facility
- Hospital outpatient observation or partial hospitalization
- Partial hospitalization at a community mental health center

7. Hierarchical Condition Category (HCC) Coding

- Diagnosis coding is becoming more and more important.
- The shift from volume to value, requires HCC coding for patient acuity not just diagnosis coding for medical necessity.
- There are two major components to a patient's HCC coding score: demographics and diagnosis.
- The demographic factors are: age, gender and eligibility status.
- The diagnosis component of HCC coding, looks at all diagnosis for a patient over the past 12 months.

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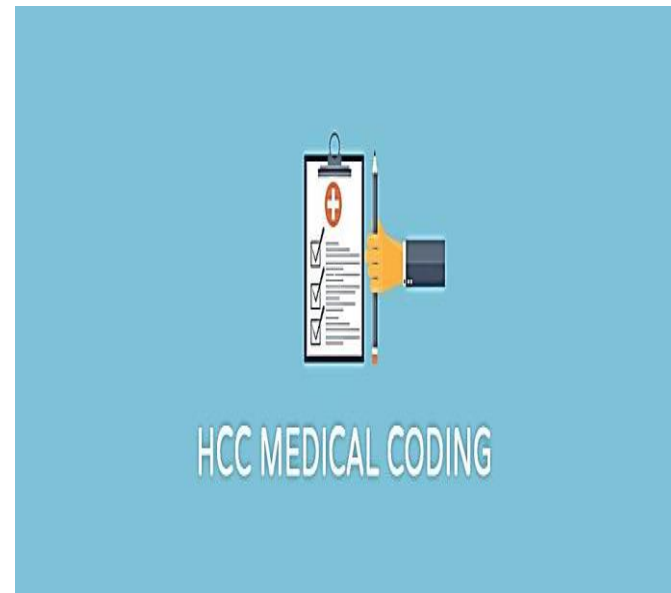
Quality Payment Program Year 3 Resources: The Quality Payment Program has free resources to help.

- Visit the official CMS website at qpp.cms.gov.
- Email qpp@cms.hhs.gov
- Call 1-866-288-8292 (toll-free)
- TTY 1-877-715-6222

You can also get support for your small, underserved, or rural practice using the contact information below:

Call 1-866-288-8292
Email QPPSURS@IMPAQINT.com

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References:

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Questions?

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