ACO REACH Quality Measurement: A Timely Discussion on Follow-Up

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Chair
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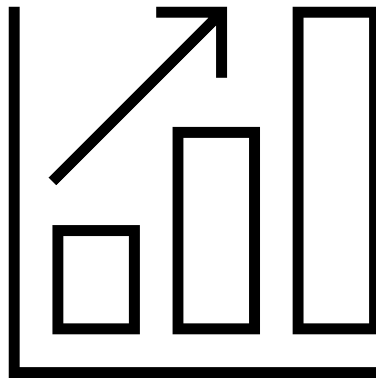
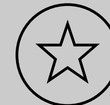
REACH Quality: Financial Impact

Total Quality Score of 100% results in 2% of benchmark earned back



Standard ACO Quality Measures
0.5% = Risk-Standardized All-Condition Readmission (ACR)
0.5% = All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions (UAMCC)
0.5% = Timely Follow-Up After Acute Exacerbations of Chronic Conditions (TFU) 
0.5% = Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Created to Achieve Superior Results Managing Risk-based Businesses:

Lumeris Group Holding Corporation

The Most Comprehensive, Proven, Network Enablement Platform

- Risk and operating partner to health systems and providers looking to take on and perform in shared risk arrangements
- Delivers the technology, knowledge and execution to enable health systems, payers and providers to deliver value-based care
- More than 7,000 physicians enabled and >1.3M lives under management through platform
- Manages over 60,000 Direct Contracting (ACO REACH) beneficiaries

One of the Highest Performing Independent MA-PD Plans in the Country

- 62,000+ member Medicare Advantage plan in Illinois, Missouri and Northern California
- A licensed Medicare Advantage plan in 8 states (MO, IL, CA, OH, KY, GA, AR and IN)
- Top 1-2% by CMS* for MA-PD plans for 13 years
  - 5 Star "Plus" ratings in 2022 and 2023
  - 2023 Raw Star score of 5.115

** Lumeris' Flagship MAPD (Essence Healthcare Missouri/Illinois) received CMS' highest 5.0 Star rating for 2022 and 2023.*

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About Lumeris

With Lumeris as a partner, health systems across the country are fulfilling the promise of value-based care. A joint-operating partner in both value and risk, Lumeris delivers market-leading technology, insurance capabilities, and on-the-ground expertise to more than one million patients and 7,000 physicians nationwide. Lumeris is proud to offer 4.5-5-star health plans that consistently deliver better clinical and financial outcomes for Medicare, Medicaid, Commercial, and Individual populations. Discover the perks of partnership at Lumeris.com.

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Timely Follow-Up After Acute Exacerbations of Chronic Conditions (TFU)

Quality Measure Definition

ACO-level rate of follow-up for patients with chronic conditions who have experienced an acute exacerbation of one of six conditions of interest, which can be attributed to providers participating in the model.

Measure Overview

This is a measure of follow-up for patients with chronic conditions who have experienced an acute exacerbation hypertension, asthma, heart failure (HF), coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD), or diabetes, which can be attributed to providers participating in the ACO REACH model. Results of the measure are aggregated on an ACO level. CORE is currently respecifying the Timely Follow-up After Acute Exacerbations of Chronic Conditions Measure, which was originally specified by IMPAQ, NQF #3455.

Rationale

Patients hospitalized or seen acutely in the emergency department (ED) and hospital outpatient departments for exacerbations of chronic conditions are at high risk of readmission and poorly coordinated care, which may increase healthcare spending, worsen healthcare outcomes, and result in poor quality of life. Evidence has shown that **delivering clinically appropriate follow-up care and improving care coordination can improve healthcare outcomes, reduce readmissions, and reduce healthcare costs.** The intent of the Timely Follow-Up measure is to **encourage appropriate follow-up care and improve care coordination at discharge**. A systematic review has demonstrated that, when coupled with other types of discharge support, **timely follow-up does positively contribute to health outcomes and is a key component of high-quality healthcare.** We anticipate the Timely Follow-Up measure will encourage model participants to improve care coordination and produce long-term savings for a given healthcare system.

Timely Follow Up After Acute Exacerbations of Chronic Conditions (TFU)

Infrastructure

Where are my ACO REACH patients?

- HIE
- ADT feeds
- Health system discharge reports within EMR
- What fields of info are available?
  - Discharging hospital name
  - SNF name
- Vendor partners /aggregators of discharge destinations

What resources & processes in place for scheduling follow up visit?

- Hospital CM
- PCP Clinic
- TCM billing process
- Transition of Care process
- Digital outreach process (EMR message; Texting)
- Central resources

Aligned Physician incentives

- PCP level – drive access improvement
- Evaluate all post discharge follow up VBC measures to design incentive

Visibility to performance data

- Who needs to see data?
- Determine proxy leading/process measures
- How will you measure?
- Transparency to drive improvement

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Care Redesign / Care Team

Assess current state

- Focus efforts for improvement
- What resources or other initiatives align?
- Who receives the transition notification?
- What action do they take?
- How does the process connect to Transitions of Care program?
- How does the process connect to Transitional Care Management (TCM)?

What is the gap?

- Access
- Scheduling appointment process

What is the hand-off to ambulatory CM or PCP for follow up visit?

- Health system EMR
- Risk stratification notifications

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Timely Follow Up After Acute Exacerbations of Chronic Conditions (TFU)

Implementing & Measuring Performance

What is our implementation approach?

- Narrow focus on each CMS diagnosis and time frame in the TFU data definition
- Broad approach - perhaps aligned with other quality measures for appropriate follow up for all VBC populations
  - Readmission risk stratified
  - Set timeframe – 7 days? 10 days? 14 days?

Visibility to performance data

- Understand the measure
- Understand claims delay
- Determine proxy leading/process measures
- Transparency to drive improvement

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Spirit of the Measure / Alternatives

ED & IP DISCHARGE: FOLLOW-UP WITHIN 10 DAYS

The percentage of emergency department (ED) visits and inpatient discharges for Patients 18 years and older who have multiple high-risk chronic conditions and who had a follow-up service within 10 days of the ED visit or discharge.

Meeting the Measure Criteria:

- Patients who received a follow-up service within 10 days after the ED visit or inpatient discharge (8 Days total).
- Visits on the same date of the ED visit and inpatient discharge meet criteria.

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Timely Follow Up After Acute Exacerbations of Chronic Conditions (TFU)

Two DCE Entities TFY Care Model

Practice #1

- Central Care Managers providing TOC support
- Broad approach to follow up appointments – all ACO REACH patients; all PCPs
- Narrow timeframe – within 7 days
- Allocate Care Managers to follow pts in hospital and notify Care Management team of transitions
- Leverage HIE and tech enabled transition notifications
- Attempt to schedule appointment with own PCP first
- Next option is NP visit in the home or virtual
- Tracking 10- & 30-Day readmissions
- Required report out to Quality Committee

Practice #2

- Central Care Managers providing TOC support
- 3 practice local Care Managers to be reallocated to more ACO REACH patient transition support
- Targeted approach to follow up appointment improvement based on physician level performance
- Narrow timeframe – within 10 days
- Broad approach – All ACO REACH patients
- Leverage HIE and tech enabled transition notifications to clinics staff directly to outreach for appointment
- Required report out to Quality Committee

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Timely Follow Up After Acute Exacerbations of Chronic Conditions (TFU)

Barriers & Recommendations

- Claims based diagnosis not available at time of discharge
- Disagreement between admit and discharge diagnoses to claims diagnoses
- Overly broad interpretation of exacerbation of the chronic condition
- Difficult to implement process precisely in real time
- Could impact follow up access appointments negatively being used when not needed in that timeframe

- Consider additional process and leading measures
- Provide feedback to CMMI
- Support CMMI providing an evaluation of this quality measure – is it providing valuable information or facilitating a change in completing follow up visits
- Advocate for standard HIE fields and utilization
- Leverage technology to know where patients are and interacting with them
- Use patient risk stratification to determine appropriate follow up time frames
- Automate follow up scheduling process

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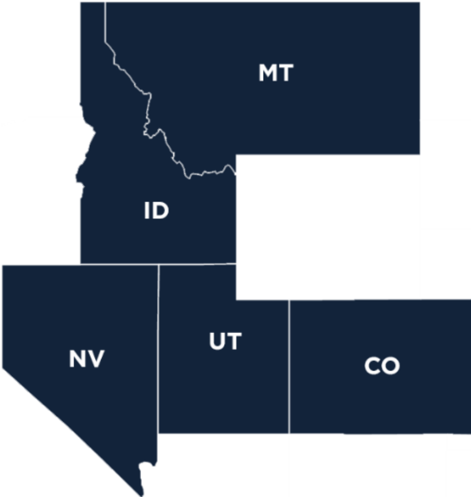
CASTELL

NAACOS Panel Discussion: Timely Follow-up
Castell and Intermountain Health Experience

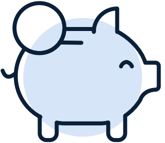
Castell At A Glance

Intermountain Health's Population Health Platform Company

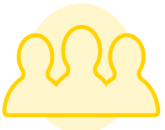


5 states

~1.2 Million
lives under management



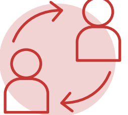
~$5 Billion
in value-based care arrangements



~550
employees

Advanced data & analytics platform

860
employed providers



840
affiliate providers

Multi payer value-based relationships

Full spectrum of value-based care arrangements

Medicare Shared Savings	Medicare Direct Contracting	Medicare Advantage	Managed Medicaid	Individual ACA	Commercial

Intermountain/Castell TOC Focus 2018-2022

- Focus on patients with high readmission risk after inpatient discharge
- Goal to reduce readmissions and reduce unnecessary medical expense
- Scheduling follow-up with PCP within 7 days
- Primary care providers supported by care coordinators to schedule follow-up for other patients based on PCP judgement

	Readmission Rates by Readmission Risk Score			
	40-49	50-59	60-64	>64
Readmission Rate Patients w/o 7 Day Follow-up	6.5%	9.4%	14.5%	25.3%
Readmission Reduction 7 Day Follow-up Completed (95% confidence interval)	-0.0% (-0.7%, 0.7%)	-0.6% (-1.6%, 0.6%)	-1.2% (-1.9%, -0.4%)	-2.1% (-4.4%, 0.3%)

Pharmacist TOC Med Reviews 2021-2022

- Pharmacist telephone visit with patient on post-discharge day #2
- Targeted to medical patients with 10+ medications, high-risk medications, high risk disease states

1.6	2.6	7.6%	$1:7.3
Average medication-related issues per patient	Average actions taken per patient	Absolute readmission risk reduction (20.2% vs 12.6%)	Return on Investment

Castell Transition of Care Infrastructure 2022+

Nurse Care Manager

Pharmacy Tech

Home Visit Social Worker

Pharmacist

Home Visit Provider

Care Coordinator

Data/Analytics

Clinical Pathway for Comprehensive TOC Support

Clinical Data

HIE Connection

Readmission risk

Intervention criteria

Coordination of Care

Care Coordinator (non-licensed)

Before discharge or within 24 hrs

Identify immediate risks

Schedule visits with other team members

Pharmacist or Pharmacy Tech

Care Manager

Home visit

Social Needs

Timing dependent on readmission risk

Insights available from other team members

Care Manager

Pharmacist

Care Coordinator

Follow-up provider visits

Home visits

Barriers to Success

- Timely Reporting
- Complexity of different measures
- Primary Care/Specialty Care Access
- Coordinating care between multiple team members

Complexity of Quality Measure Designs

Intermountain Health High-Risk Hospital Discharge	ACO Reach: Timely Follow-Up (TFU)	Stars: Transitions of Care (TRC)
• Based on readmission risk score • Focused on Inpatient Admission • Appointments completed within 7 days	• Not focused on high readmission risk score • Includes ED, observation or inpatient stay • Specific to hypertension, asthma, HF, CAD, COPD and diabetes • Follow-up timeframe adjusts based on condition and acuity.	• All Inpatient Discharges • Focused on medication reconciliation • 30-day timeframe for all patients • Provider visit not required

UpStream

Timely Follow-Up Discussion

Mark Reardon, MD MBA
SVP & Chief Quality Officer
NACCOS Fall 2023

UpStream mission:

We exist to eliminate the burden of chronic disease.

UpStream Snapshot

UpStream offers a transformative healthcare approach for elders with multiple chronic conditions. Recognizing the limitations of primary care physicians in providing advanced care, UpStream embeds specialized clinical support teams within existing practices.

These teams, consisting of prescribing pharmacists and coordination nurses, collaborate with primary care physicians to deliver upstream clinical interventions, reducing avoidable downstream healthcare costs. Developed in the 1990s, our model emphasizes team-based care and a unique patient workup methodology, setting new standards and redefining value-based care.

Over 140k

Seniors supported by UpStream partnered practices.

20%

Lower costs for patients engaged on the platform.

4.5 Stars

Achievable for providers engaged on the platform.

1,000+

Participating primary care providers.

There comes a point where we need to stop pulling people out of the river and go upstream to find out why they are falling in.

DESMOND TUTU

Five Why's Continuum

Male Patient
74 Y/O
—
Medical history:
- Coronary artery disease
- Prostatectomy
- Hypertension

—
Sepsis ICU Admit
Patient presented with fever, hypotension & tachycardia

WHY?

1
Because they had a UTI and could not contact anyone at their primary care office

WHY?

2
Because they had a Foley catheter and didn't know how to care for it properly

WHY?

3
Because there was no coordination, education or homecare services after their prostatectomy

WHY?

4
Because no one person owned the responsibility for the patient's care

WHY?

5
Because WE failed to schedule the primary care appointment and coordination was absent

SO?

IN-PATIENT CARE → HOME-BASED CARE → OFFICE-BASED CARE → SELF CARE

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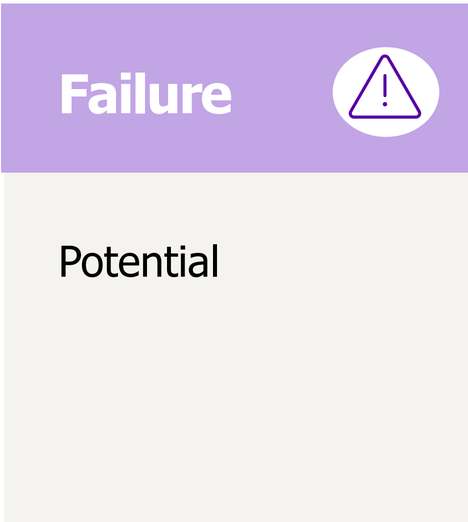
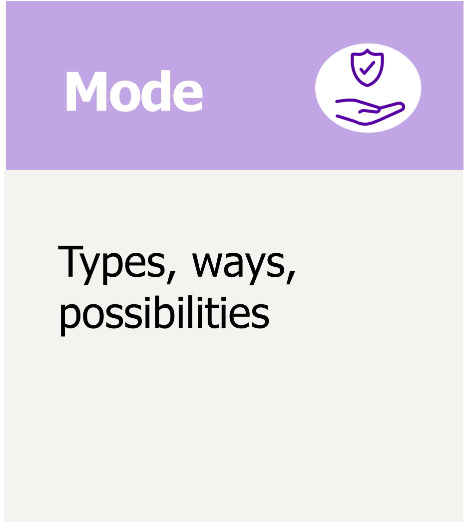
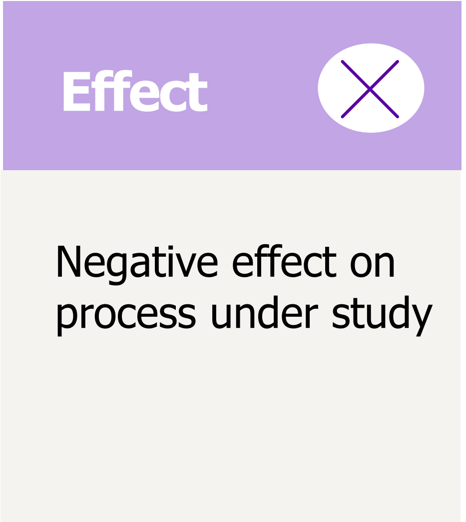
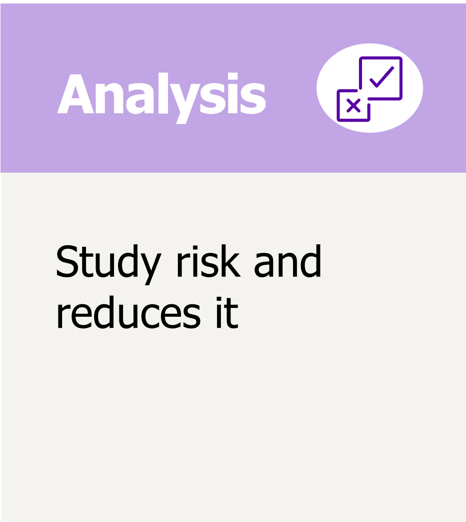
Significant Failure Potential Post-Exacerbation

FMEA









Physician Alignment Critical for TFU Success

Successful physician alignment hinges on:

1. **Data** timely
2. **Resources** additive
3. **Incentives** transparent

We have found success with **concurrent** value-based payment program for physicians – selecting from common MA and REACH measures

Biggest **challenge is balancing parsimony** with broad **performance**

Challenges Vary by Organization Type

Small Independent Practices	Large Independent Practices	Mid-Size ACOs	State-Wide Provider Networks	Integrated Health Systems
• Expensive data infrastructure to calculate measure • But, often better knowledge of patient population!	• Expensive data infrastructure to calculate measure	• Need to formalize enterprise performance management • Economies of scale with data infrastructure	• Communication and education requires coordinated investments • SDoH resources easier to align state-wide	• Physician incentive and compensation models trickier • Measure risk adjustment / baselining opportunities