Managed Care-
Creating a Culture of Quality

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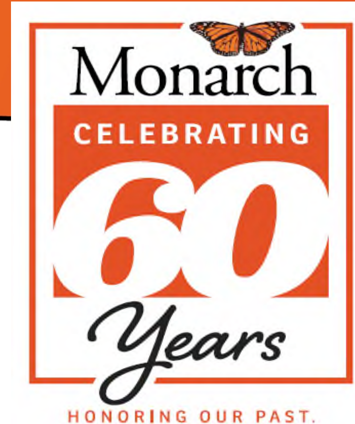
Chief Operations Office/ Executive Vice President

Agenda

- Who is Monarch
- Provider of Quality
- Performance Outcomes

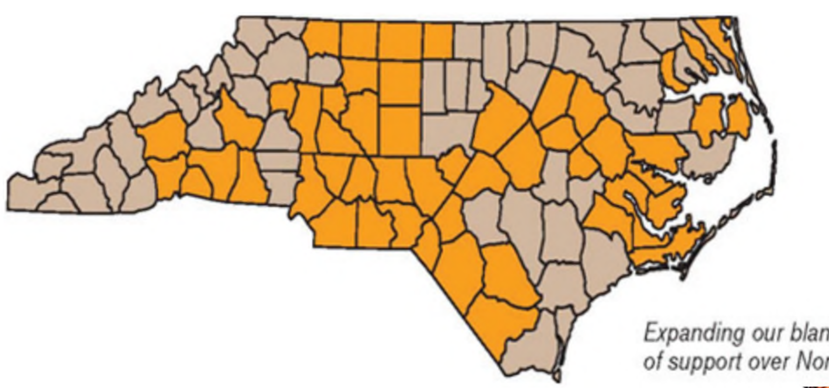
Who is Monarch?



Established in 1958

Monarch is a **not-for-profit organization** that provides support statewide in North Carolina to thousands of people with:

- Intellectual and developmental disabilities
- Mental Illness
- Substance Use Disorders



Expanding our blanket of support over North Carolina

Nationally accredited by:
The Joint Commission

Who is Monarch?

Monarch operates **The Arc of Stanly County,** which is a chapter of The Arc of North Carolina and The Arc of the United States.

Serve about 30,000 people
About 4000 of those have I/DD

About 1800 employees
Budget of 90 Million

www.MonarchNC.org

What does Monarch do?
LTSS (Long Term Services and Supports)

- Residential options
  - 4-6 bed group homes
  - Roommate apartments
  - Individual apartments
  - Periodic supports from two hours/week to 24/7
- Day Support Services
  - Full day support
  - Volunteering
  - Community activities
  - Creative Arts Center
  - Employment

- General community Services
  - Employment
  - Beyond Academics
  - Respite
  - Periodic supports
  - Crisis services
  - Psychiatric services

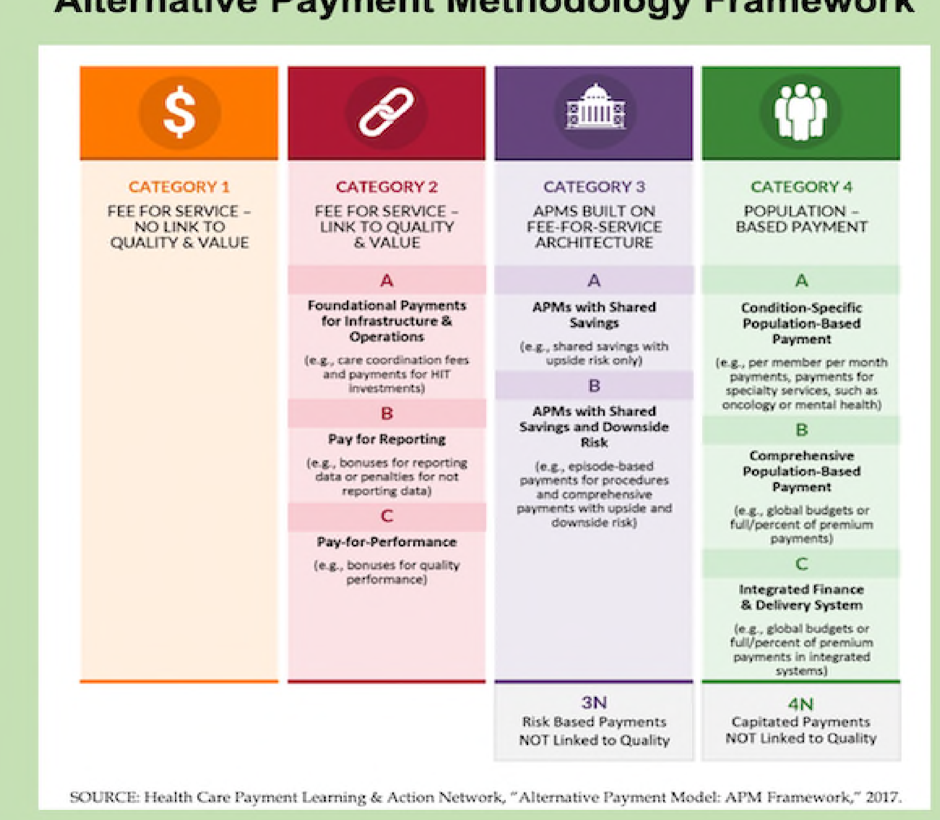
What does Monarch do? – Behavioral Health

- Outpatient clinics (specialty in I/DD)
- Urgent Care (BHUC)
- Intensive In Home
- Psychosocial Rehabilitation
- Supported Employment (IPS)
- Facility Based Crisis (child and adult)
- Peer supports
- Care Management -pilot
- Integrated Care
  - Placement of Outpatient offices with other niche services (SUD, OB/GYN, etc.)
  - Psychiatrist consultation
  - CCBHC with case management and primary care physician (PT)

Why focus on performance outcomes?

- Current state of payment
  - Fee for service
    - Head in the bed is gone
    - Coding
    - Add on codes
  - Value based payments
    - Approximately 93% of Medicaid Managed Care Organizations (MCOs) reported using value-based payments or alternative payment models in 2019.- Open Minds (January 2020)
  - Pay for outcomes for individuals, not programs or services

CMS- Methodology Framework



Where are we headed?

- In September of 2020, Centers for Medicare and Medicaid Services (CMS) issued guidance to states.
  - "Align payment incentives and performance measures across their health care systems to reduce the burden on providers who participate in multiple programs"
    - Open Minds (January 2020)

The payor translation

Value-Based Care Payment Model

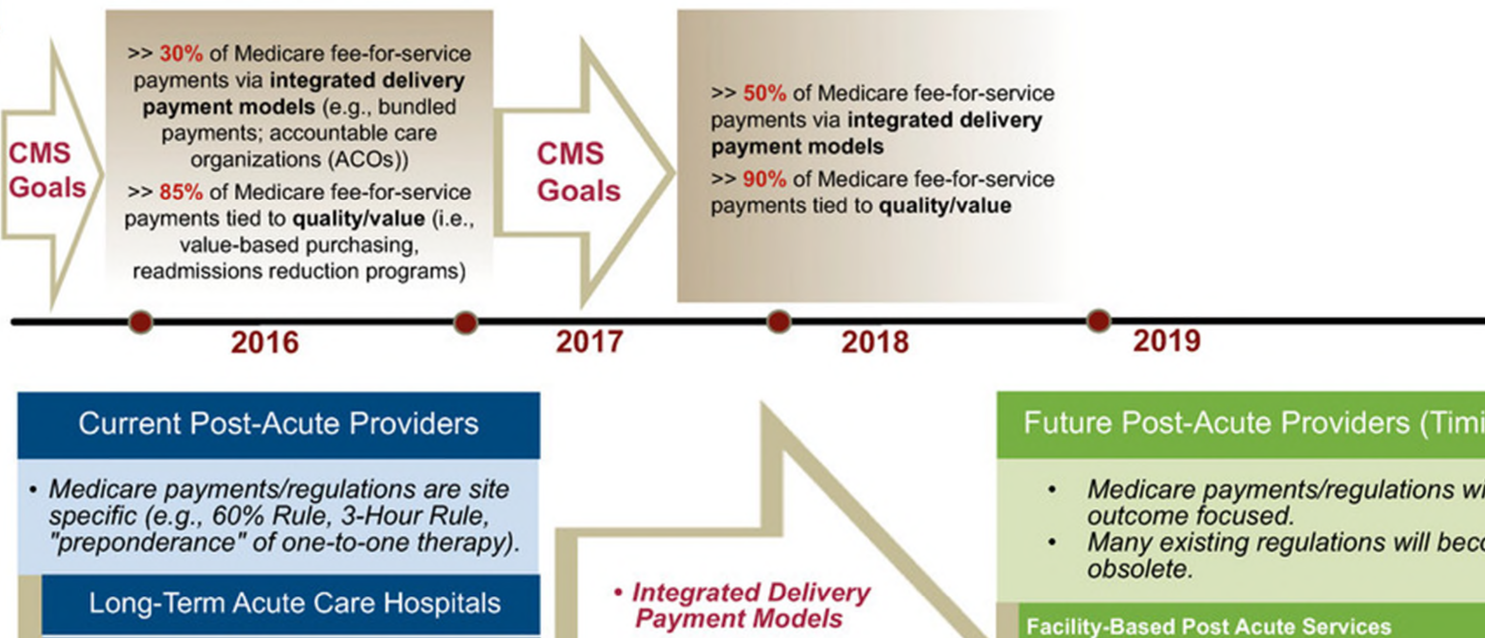
IMPROVE QUALITY

ENHANCE PATIENT EXPERIENCE

LOWER OVERALL COSTS OF CARE

REIMBURSEMENT FROM PAYER

CMS: Driving Change Toward Integrated Delivery Payment Models, Value-Based Purchasing



Source: Health and Human Services Fact Sheet announcing new reimbursement goals - January 26, 2015

How do we start?

- Define Performance Improvement
- Measuring Improvement
- Define Plan Do Study Act (PDSA)
- Being a Provider of Value
- Performance Improvement

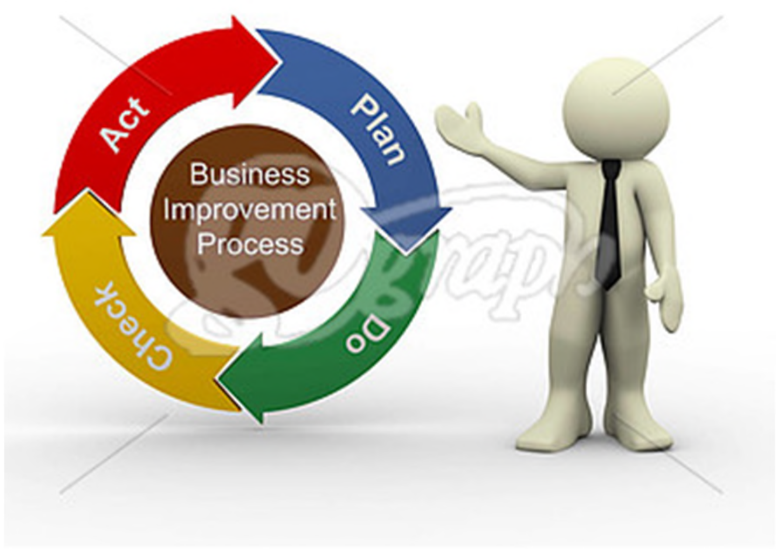
What performance improvement is not

- Tracking and monitoring incidents
- Measuring number of incidents submitted on time
- Measuring number of people that have person centered plans
- Measuring the number of times someone uses negative behavior to get something
- Measuring the number/type of prompts it takes to do a task

- In other words – PI is not measuring “Did something happen?”
- It is measuring “Did someone’s life improve?”

What is Performance Improvement

Systematic and continuous process of assessment and action practices that lead to measurable improvements



Ultimate Goal – Continuous Improvement

Need to create a PI culture to support and sustain performance improvement

(Starts from the top)

- Create urgency for improvement
- Communicate vision
- Empower and train staff
- Build on successful projects
- Embed performance improvement into all departmental plans

Principles of Performance Improvement

Continually Improve quality systems and processes

Improve services for Persons' Supported

PI

Employee Input and quality culture (Team)

Utilize data, policies and industry standards to make decisions

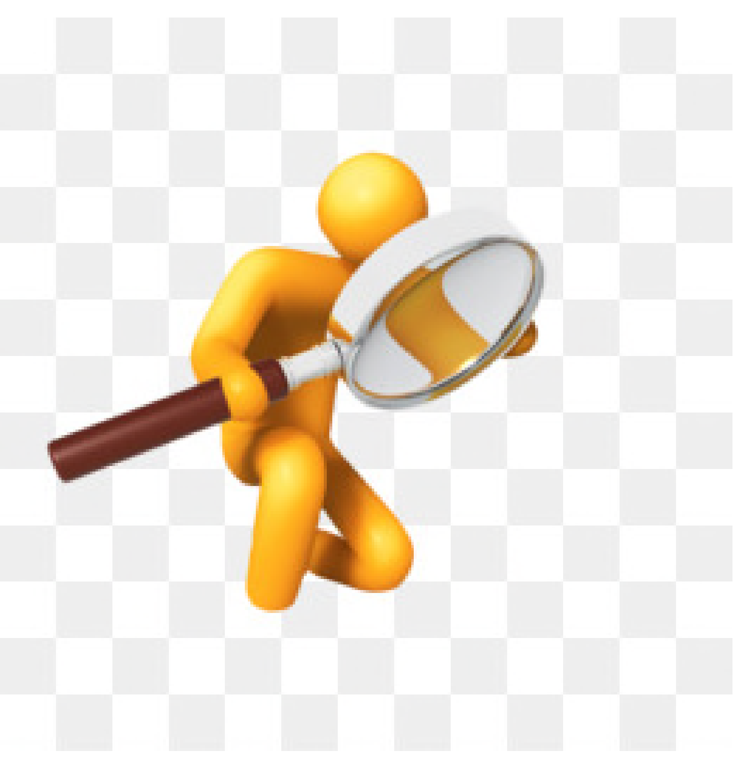
Why is Performance Important Necessary?

- Improves staff performance
- Improves safety of those supported
- Indicates whether changes lead to improvements
- Supports accreditation
- Your future funding depends on it

No thanks!
We are too busy

University of Manitoba
Rady Faculty of Health Sciences

How do we measure improvement?



How do we measure improvement?

Measurement based tools (PHQ9, GAAD)

Experience of care/ satisfaction surveys

Identified performance outcome measures

Data analysis

Audit tools/ Fidelity to model

Benchmarking

It's all about data

- Utilize data, policies and industry standards to make decisions
  - Example - Need more staff?
- Data justifies payment
  - Example PHQ9
- Data is used to monitor system effectiveness and inform
  - Are we meeting our goals and expectations?
  - Is the treatment or service effective?
  - Did our improvement actions work?

PQH9 as a Data Outcome

- The shaping conversation
  - Who is doing it?
  - How often do people do it?
  - Do it every two weeks
  - Measure aggregate change
  - Measure aggregate change by intervention (meds v therapy and meds)
  - Stratify (age, income, education, etc.)
  - Improve and Report

Performance measurement tells you what is really happening, as opposed to what you think is happening.

PI – Plan Do Study Act (PDSA)

Difference Between PI Plan and PI Activity

PI Plan Agency System Focused	PI Activity Process/Service Focused
Written documentation to describe the agency's approach to performance improvement	Using performance improvement methods and tools to improve service and quality
Planning and systems surrounding the PI	Actually completing the PI and measuring outcomes

PI Activity Sources

PI activity can be generated from many sources:

- Quality assurance data
- Audit findings
- People we support feedback
- Staff feedback
- Accreditation results
- Leadership team
- Reporting or Safety outliers
- Clinical pathways

It's Time For A Break
EXMEN

Being a Provider of Value

Value and Health Care

- Value in health care is measured by the outcomes delivered, not the volume of services delivered and shifting the focus from volume to value is a central challenge
  – Michael Porter, Ph. D., Author, Harvard Business School

Provider of Value

- Common Denominators to the factors for sustainability of the Provider of Value
  - Data
  - Systematic analysis
  - Providing services that will produce desired outcomes
  - Meeting the needs of the payor
  - Value based purchasing/ Incentivized contracts

Value- Based Reimbursement

Value-Based Reimbursement Changes The "Value Measures" Of Clinical Professional Performance

VBR Arrangement	Typical Performance Measures	Staffing Performance Implications
FFS With Performance Incentives	• Reduced ER use and reduced readmissions • Rapid access to care • Positive customer experience	• Proactive responsiveness to consumer needs and collaboration with other clinical professionals • Flexible schedule and "on call" availability • Interpersonal skills that contribute to positive consumer interaction • Ability to understand the value-based business model – customer experience, productivity requirements, contracted outcomes
Case Rates Or Bundled Payments	• Delivery of consumer service experience in a fixed budget • Continuum of care coordination	• Use of clinical decision support tools for best practices • Development of community relationships to coordinate care needs
Capitated (PMPM) Arrangements For Care Coordination Or Services	• Delivery of consumer service experience in a fixed budget over time	• Ability to use tools to coordinate consumer care over time • Use data and health system relationships to coordinate services along the continuum of care

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Shared Goals = Better Outcomes

Providers

- Showing value
- Knowing people are getting better but can't prove it- no data
- Available data doesn't tell the real story
- Cannot afford the requirements

Payors

- Paying for value
- Have lots of data and do not know if people are getting better
- Available data doesn't tell the real story
- Cannot afford the cost

Managed Care

Deliver whole-person care through coordinated physical health, behavioral health, intellectual/ developmental disabilities and pharmacy products and care models.

Address the full set of factors that impact health, uniting communities and health care systems.

Perform localized care management at the site of care, in the home or community

Maintain broad provider participation by mitigating administrative burden

Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment Income Expenses Debt Medical bills Support	Housing Transportation Safety Parks Playgrounds Walkability	Literacy Language Early childhood education Vocational training Higher education	Hunger Access to healthy options	Social integration Support systems Community engagement Discrimination	Health coverage Provider availability Provider linguistic and cultural competency Quality of care

Health Outcomes

Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

Housing

Housing is one of the more critical determinants of good health.

Housing plays a major function in maintaining health and wellbeing. Housing provides shelter, safety, security and privacy.

The availability of affordable, sustainable, and appropriate housing enables people to participate in the social, economic and community of their lives.

The growing population, policies and other factors have an impact on supply, demand and cost of housing. The absence of affordable, secure, and appropriate housing has negative consequences e.g. homelessness, poor health, lower rates of employment and education.

Value Based Services

- For IDD
  - What difference does the service or support mean to me?
    - Self Direction
      - Living in a way that is based on having control of one's life, exercising rights, having freedom and happiness
      - Quality of supports
        - » Friends, Opportunities, choices, staff

Whole Person Care

- Care Coordination Platforms
- Timeliness of support or intervention
- Looking at all of the venues of services and supports
- Ability to inform the discussion with the individual based on information- not relying on verbal reporting
- More holistic approach to resources available or not available to support the individual
- More efficient use of time

Outcomes

Improve	Improve the experience of care
Improve	Improve the health of populations
Reduce	Reduce per capita costs of health
Improve	Improve coordination of care
Provide	Provide care which is appropriate and meets the needs (not just what is available)
Transition	Transition of care delivery and payment arrangements that align quality and cost incentives

Outcomes Measures with IDD

- Developing service options to better meet the needs of individuals and families in a true, person-centered way
- Ensuring that individuals live in the most integrated community setting
- Increasing the number of individuals who are competitively employed
- Focusing on personal outcome goals for individuals such as improved life or access to meaningful activities

Examples of Measures

Intervention or Supports resulted in an improvement in quality of life:

Employment - % who maintained/obtained employment or higher education status

Participation in community activities

Meaningful day activities

Integrated Housing - % with maintenance of stable or improved housing status

People choosing where and with whom they live

People choose where they work

Participate in the life of the Community

Physical Health Measures

1

Promote Wellness and Prevention

2

Maximize long term services populations quality of life

Improve chronic condition management

- Improve diabetes management
- Improve asthma management
- Improve hypertension management
- Address obesity
- Address tobacco use

Physical Health Measures

- Concept of using “physical health” measures instead the typical behavioral health measures to see what the acute/physical health arena is looking at and how behavioral health/IDD must shift to be part of the system and not an isolated carve out

- Effectiveness of care, services and supports:
  - Do hypertension patients have their blood pressure under control? Are people with BH/IDD getting the same type of medical care as the typically developing individual?

- Access:
  - Were patients able to get an appointment with their Primary Care Physician? How long was the wait time to get waiver services – the registry of unmet needs?

- Utilization:
  - What was the average length stay in a hospital for a chronic condition?

Physical Health Measures

Relative Resource Use (RRU): Measures examine the intersection of quality and cost to measure value and efficiency

Is there a way to build capacity to be offer physical health as well as behavioral health?

Examples of Measures

- Preventative care
  - Individuals with IDD may experience difficulty undergoing routine examinations and procedures
- Hospitalization and over medication
  - May be more common for individuals with IDD
    - Medication reconciliation measures
    - Antipsychotic polypharmacy- 3 or more
    - Adherence to medications
- Dental visits
- Body Mass Index (BMI)

Examples of Measures

System structures to connect health system and services

Communication to/from primary care, other providers, other SDoH agencies, partners

Appropriate prescribing/comprehensive medication management

Screening for cognitive impairment, poor psychosocial health, poor health literacy

Optimal functioning (e.g., improving when possible, maintaining, managing decline)

Examples of Measures

- Sense of control/autonomy/self-determination
- Independent living skills
- Smart Homes
- Level of beneficiary assistance navigating Medicare/Medicaid
- Active is discharge/transition activities of life

How to be an engaged provider?

- Look for measures that your services can impact – linked to physical health – not just the behavioral health
  - Accountable Care Organization Measures
  - HEDIS Measures
  - Certified Community Behavioral Health Center (CCBHC) Measures
  - Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

- Know the “value” of impacting the measure and the cost

- What practice changes are necessary to achieve the targeted outcome

Continuous Quality Improvement

- Part of the management of all **system** and **process**
- Achieving the **highest of performance**
- The process of continues improvement must contain regular cycles of **planning, execution and evolution**

Performance Improvement

What can I do?

What is a good way to demonstrate that people have great, cost effective outcomes?

What is the most important area of your work that requires improving?

PI discussions can occur during team meetings that focus on people we support and/or program business

Scorecards

Performance Improvement

What can I do?

Establish an improvement team across disciplines

Identify staff who have the most knowledge of the selected area for improvement.	Assign a team leader who will take responsibility for the team.	Exchange ideas about potential barriers	Discuss interventions

What is in Monarch’s PI Plan

Effective PI plan includes:

- Mission, vision, values and strategic plan
- PI goals and objectives
- Description on how PI activities are selected
- Quality Methodology – PDSA and MFI
- Planned PI activities for the fiscal year
- Team/ Committees involved
- Data method, collection, reporting

What is MACRA and MIPS

MACRA - The Medicare Access and CHIP Reauthorization Act of 2015 created the Quality Payment Program that:

- Repealed Sustainable Growth Rate Formula
- Changed the way that Medicare rewards clinicians for value over volume
- Streamlines multiple quality programs under the new Merit Based Incentive Payments System (MIPS)
- Gives bonus payments for participation in eligible alternative payment models (APMs)

What is MACRA and MIPS

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

PQRS + MU + VBM
Maximum Total Penalties

- **2015:** 4.5%
- **2016:** 6%
- **2017:** 9%
- **2018:** 10% or more
- **2019:** 11% or more
- **2020:** 11% or more

PQRS: Physician Quality Reporting System
MU: EHR Incentive Program/Meaningful Use
VBM: Value-Based Payment Modifier

Merit-based Incentive Payment System (MIPS) Maximum Penalties & Bonuses

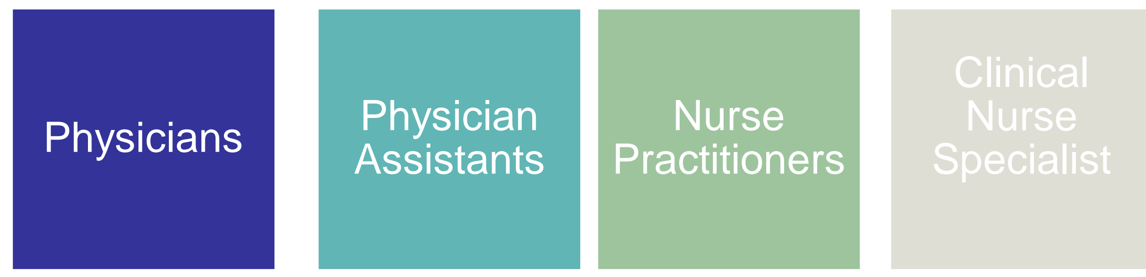
- **2015-2018:** PQRS, MU, VBM continue.
- **2019:** **4**% (Extra bonus possible)
- **2020:** **5**% (Extra bonus possible)
- **2021:** **7**% (Extra bonus possible)
- **2022 & after:** 9% (Extra bonus 2022-2024)

Extra bonus 2019-2024: Up to 10% for exceptional performance (up to $500 million/year). MIPS has more accurate assessment, scoring, flexibility, predictability than under PQRS, MU, or VBM.

Clinicians who Participate in MIPS

Clinicians billing more than $30,000 to Medicare Part B a year AND providing care for more than 100 Medicare patients a year in 2017.

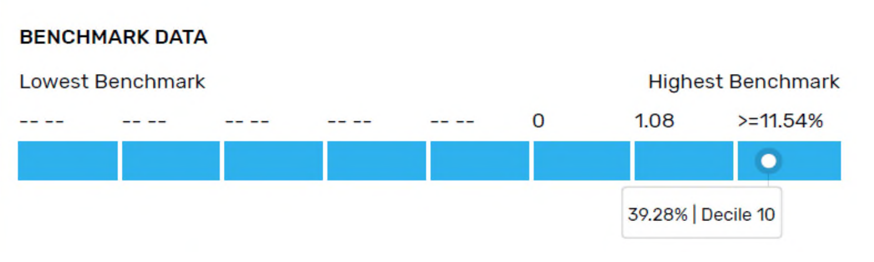
Clinicians Include:

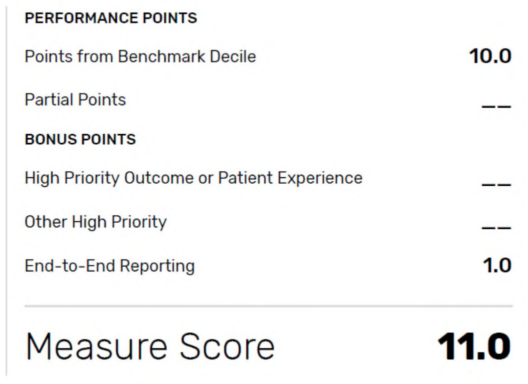


Quality Measure #371
Did you ever consider using this for your folks?

Depression Utilization of PHQ-9 Tool

- Age18 and older
- Diagnosis of major depression or dysthymia
- Patient Health Questionnaire (PHQ-9) tool administered at least once during a 4-month



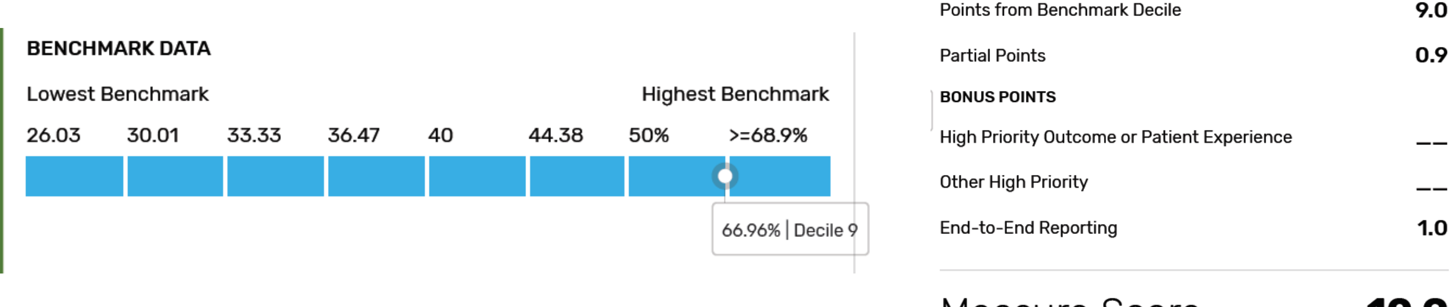


CMS Measure Logic provided by HealthIt.gov
https://ecqi.healthit.gov/system/files/ecqm/measures/CMS160v5_2.html

Quality Measure #128
Do you track this in the aggregate?

Preventative Care and Screening: Body Mass Index (BMI) Screening and Follow-up Plan

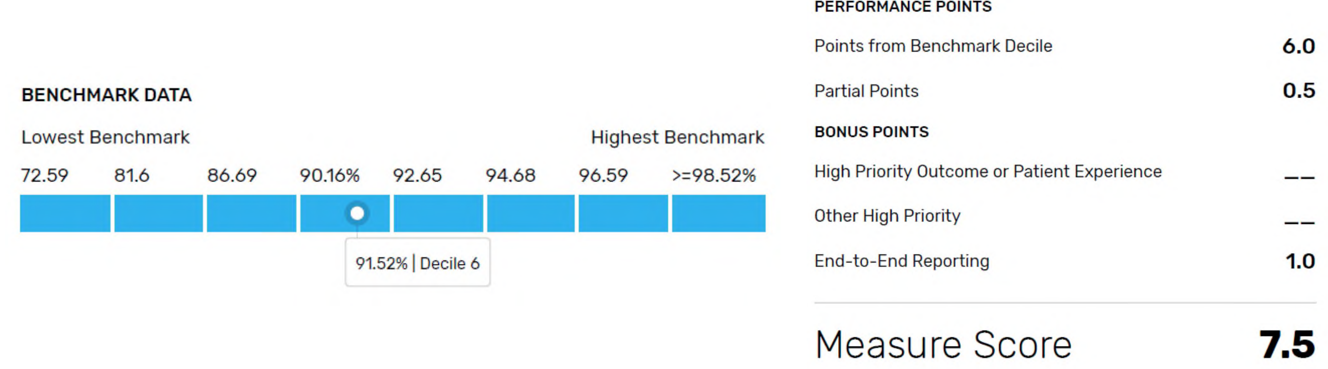
- Age 18 years and older with a BMI documented during the current encounter or during the previous six months
- If BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months (BMI => 18.5 and < 25 kg/m2)



Quality Measure #226

Preventative Care and Screening: Tobacco Use Screening and Cessation Intervention

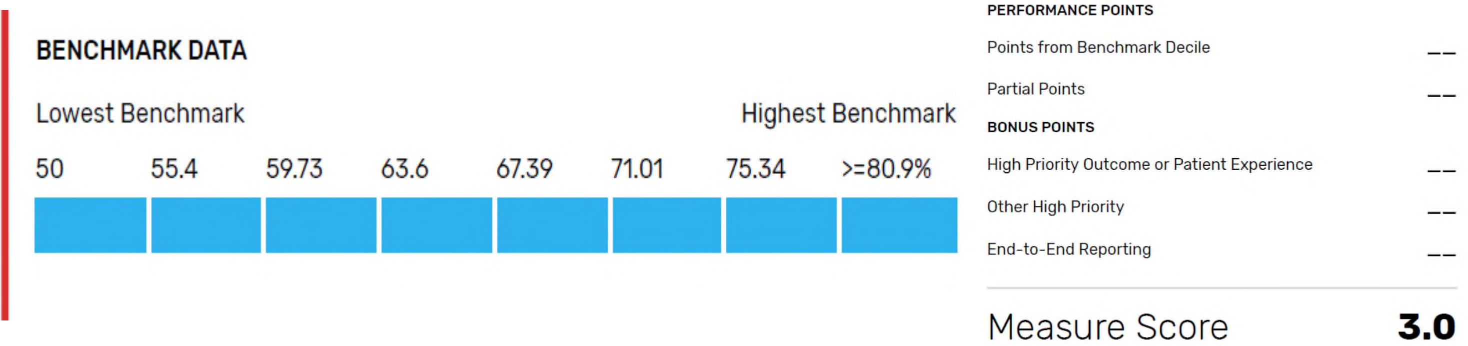
- Age18 years and older
- Screened for tobacco use one or more times within 24 months
- If user, received cessation counseling intervention



Quality Measure #236

Controlling High Blood Pressure

- Age18-85 years of age
- Diagnosis of hypertension
- Blood pressure was adequately controlled (<140/90mmHg) during the measurement period



Benchmark was 9.3% - Measure has scored below the lowest decile and received the minimum three points. Measure chosen because only outcome measure

Quality Measure #130
You already do this!

Documentation of Current Medications in Record
(High Priority)

- 18 years and older
- Documented list of current medications on the date of the encounter.
- Must contain the medications' name, dosage, frequency and route of administration.

Current Data – 64.03% **(Earned Bonus Point)**
Benchmark – 75.59% – 99.76%
Points Earned: 1.0 point for High Priority

2017 Quality Benchmark –

Quality Measure #238

Use of High-Risk Medications in the Elderly

(High Priority)

Age 66 years of age and older who were ordered high-risk medications. Two rates are reported.

a. Ordered at least one high-risk medication.
b. Ordered at least two different high-risk medications.

Current Data – 7.19% **(Earned two bonus points)**

Benchmark – 29.53% – 0% (Lower score indicates improvement)

Points Earned – 8.4 points - Measure was Topped Out, but received 2 bonus points - high priority

A final thought

Be a yardstick of quality. Some people aren't used to an environment where excellence is expected.

Steve Jobs

Thank you

Everything we do can be summed up into two words, we care.

Presenter Information

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