Using Value Based Care (VBC) to Foster Innovation

This Q&A is with leadership of the Office of Value Based Performance at the University of Colorado Medicine (CU Medicine), including Lisa Schilling, MD (medical director), Christina Finlayson, MD (senior medical director), and Chelsea Ganger (program specialist). CU Medicine created the Office of Value Based Performance in 2015 to coordinate the activities supporting Meaningful Use, Physician Quality Reporting System (PQRS), commercial value-based contracting, and Ambulatory Health Promotion, which provides centralized support for the closure of care gaps. In this interview, the leadership team discusses how CU Medicine is working to improve patient experience through investments in value based care, quality initiatives, and innovative technology.

As part of their value based care (VBC) portfolio, CU Medicine joined the Comprehensive Primary Care Plus Program in 2017 and the Primary Care First (PCF) Model in 2021. The Center for Medicare and Medicaid Innovation created both programs to improve patient experience and quality of care, while reducing expenditures. The model provides primary care practices with capitated payments to support investments in access, care management, care coordination, patient and caregiver engagement, and a population health infrastructure.

Since PCF was introduced in 2020, the AAMC has supported 65 primary care practices associated with teaching hospitals participating in the model. Our intent with this installment in our Examples in Practice series is to highlight challenges and successful strategies for organizations participating in PCF and offer potential lessons for other teaching hospitals pursuing VBC, as well as for the payers and policymakers designing alternative payment models.

What is the current state of value based care at CU Medicine?

As a state, Colorado is unique in that we do not have a predominant payer in the state, and over half of our commercially insured population gets coverage under an ERISA plan.[1] This has created an environment where there is no one potential commercial partner with enough covered lives to be able to take significant actuarial risk. We have been able to work with our commercial insurance providers to build value based programs that provide per-member, per-month payments or sharing of cost-savings based on performance on specified quality measures.

Much of our progress in providing value based care has been supported by leveraging our government payer program, particularly Medicare and Medicaid. The significant majority of our patients with these insurers are in fee-for-service models. We established the Office of Value Based Performance in 2015, bringing together our Meaningful Use team, our PQRS[2] team, and other stakeholders that were working on these primarily Medicare products. We organized the office to examine VBC performance in a holistic way.

We established a core principle that required the same quality measures across all programs to ensure that when we took on additional programs, we would have the foundation we needed for success. We have team members who monitor the development of new programs, and we also have good relationships with our private payers through our contracting office. We're always looking for new opportunities to implement programs that improve the overall quality of the care we provide.

Currently, Primary Care First represents our most significant program with dollars at risk. Our internal quality workflows integrate well into the PCF quality metrics. We have implemented workflows across the organization looking at blood pressure control, diabetes control, statin use, and the like. We're also looking at the cancer prevention screenings like colorectal and breast cancer screening, as well as behavioral health screenings for depression and tobacco and substance use. We then ensure the appropriate follow-up on those screenings is completed.

How have you engaged your physicians in VBC?

It's not just one thing that creates physician engagement in these programs. It goes back to the people, the process, and the technology. The first thing that we really try to do well is to really bring those things together. We work to identify people who care about quality and are good leaders in their respective clinics. In some cases, these are medical directors who become practice transformation champions. We give them the information and inspiration to work with us, and they help us figure out what we need to do.

Quality has been our north star for every part of our participation in value programs, and our providers have quickly come together around this approach. We started collaborating with individual specialties on quality metrics that make sense for each of those specialties, guided by the metrics we need to report. The guiding principle has

been to focus on the measures that the physicians feel strongly about and that are in their control. There may be additional measures that we report that don't hit that level yet. There are times we've had to put off focusing on something because our providers will tell us that they're not ready for that, that our system isn't ready to support us doing that. In these cases, we will still be reporting it, but it is not something we're pushing in front of our providers.

In addition to standardizing the quality measures across programs, another foundational principle is to build as much of the work as possible into the regular workflows for the practice. We did not want performance in these programs to be dependent on an individual physician knowing which boxes to check. These workflows must be consistent across all of our payers, in part because of the diversity in our payers — we don't have the patient populations to support payer-specific workflows. The team has done a really great job adopting workflows across the organization to help us achieve success. That's a big part of how we've been able to do as well as we have in the programs that we have.

How do you work with providers to design and implement quality improvement initiatives?

Our focus has been on appropriate utilization. We're not necessarily driving to decrease cost, but we are driving toward appropriate utilization. If that reduces costs, great, but it doesn't always. Sometimes, doing the right thing means doing a little bit more in the short term to ensure long-term patient well-being.

We work with our providers to examine quality around a given domain, condition, or operational function, like timely access to care. We ask the questions: "What's our baseline? Why do we want to do this better? Why is this important for patients? And really, how can we meet the quadruple aim?" We want to improve quality. We want patients to be satisfied. We want not only physicians to be satisfied, but we want the whole health care team to be satisfied.

Once we agree on the why, we then consider the barriers to quality improvement. We move on to consider the resources, people, and the tools that they need to be able to move things forward in a meaningful way. In addition, we recognize how important it is for people to see the results of their labor. So, we monitor change internally, and then we bring that information back to people so they can see their progress — this is critical to sustained engagement.

As part of this communication process, our Office of Value Based Performance has a monthly work group meeting where we share information with our practice medical directors and quality leaders about what's going on. It might be a new value-based contract, or it might be some new innovative program. It also may be certain areas where we really want to get input and motivate our teams to think more about a topic.

In the end, a lot of the work has to come from the front-line providers, and the solutions have to start there, too. We really need them to give us that information, rather than forcing solutions upon them. Our role is to support the rest of that process with data analytics, population health specialists, and our great electronic health record information technology team. We work to collaborate across our clinically integrated network to come together to get these things accomplished.

As an example, with the support of our system-wide Ambulatory Health Promotion program, we work with our providers to look at patients who have had high PHQ-9[3] screening scores but have not been back in to see their primary provider for follow-up. We call them and ensure they have appropriate care. We have them complete a repeat PHQ-9 if they tell us they are doing well and don't want to schedule a visit. If they aren't doing as well as desired, we help them set up a visit with their clinician. This centralized service gives us the opportunity to provide more holistic, well-executed, evidence-based care that is consistent across our system — taking that work away from the physicians and the individual practices.

How do you prioritize quality improvement initiatives?

The Office of Value Based Performance collaborates and provides information to the Quality Improvement Leadership Team, which chooses and implements quality improvement projects for our family medicine and general internal medicine practices. The health system also has broad initiatives around quality, and the Quality Improvement Leadership Team works to align efforts with those system-wide initiatives. Sometimes, it's about deciding to do the right thing at the right time. There are hundreds of things we want to do, and they're all important. The prioritization sometimes comes down to the initiatives that are going to have the path of least resistance and most support because others within the health system are pushing forward on it too.

A recent example is the system-wide focus on advance care planning (ACP), which became a priority partially because of COVID-19 and the resulting realization that ACP was something we should always do. It also aligned well with our Primary Care First program, which has ACP as a quality measure. That's been a great way that we

can partner with the clinics on measures that are going to be valuable within the VBC space and also have a very meaningful impact on patients' quality of life.

We have done a ton of work over the last couple years building out our approach to ACP. Some of this was sparked by our researchers, who received funding to build and test better ways to do advance care planning. We had one researcher who really led the way, and then those tools were implemented by Epic. You need those tools to be in place. You can't tell somebody to do something, but not have a mechanism within the electronic health record where they can document their discussion, how much time they spent, or access resources. We also made sure that patients had access to ACP resources and could complete things like a medical durable power of attorney on their own. Sometimes people do have to click more boxes, but you want to limit that, make it easy when necessary, and provide education so they know why it's necessary and how it improves patient care and performance with VBC.

How has participation in the CORE eConsults project changed patterns of care and influenced your VBC work?

As with many other health systems, we struggle with access to care, especially with access to specialty care. The eConsults program has really allowed us to expand access to our specialists in a way that is very helpful for both our physicians and patients. The feedback we hear is that our primary care providers appreciate being able to get their low-level questions answered in a timely fashion, without the process of needing to do a full referral and all that requires of a patient. Providers can put in a request for an eConsult in the morning and, by the end of the day, they may already have the recommendations from the specialist. Typically, in less than 24 hours, the primary care physician will have information they can act on for their patient.

The eConsults even help in the cases where a patient needs to see the specialist directly. Primary care physicians are able to tee up the visit, getting necessary lab work and the like prior to a patient going to the specialist for care. It has been especially amazing with our psychiatry department because we have some patients with very complex behavioral health needs that we see in primary care.

Even prior to the pandemic, mental health care has been very hard to get. Access is difficult, and there are patients who need assistance more acutely than they can be seen. The consult will be submitted along the lines of, "Am I doing the right things for this patient?" and it helps to get the feedback from psychiatry without having to know the full behavioral health care history of each patient.

In addition to the advantages eConsults offer for patient care, we have been able to do financial analysis that showed a statistically significant impact to costs. The use of this approach creates value for physicians, payers, and the patients they care for.

What patient engagement strategies have been most effective in getting patient feedback on new programs?

All of our primary care practices are engaged in PCF, which requires patient advisory groups. Our practices do that routinely — and they've been doing that for quite a while. Those groups provide a good opportunity to get feedback from the patients on how things are going from their perspective. As an example, we worked with one of our pharmacists to develop a packet for patients newly diagnosed with hypertension. We took it to one of those patient advisory groups and asked them for input on the material. Our system also sends out patient surveys to measure patient experience, and we look at that information very seriously.

The patient feedback can be difficult to implement in a streamlined way. When you talk to these groups, you realize that everybody is different, and everybody has a different need for receiving information in a way that they like. One thing we found was that some people wanted the whole packet at once to take home and read. Other patients were overwhelmed and preferred for their doctor to give them the information in more digestible pieces, with more information provided at follow-up appointments. We need to be flexible and meet the patient where they are, so we did both full packets and individual parts to keep in the clinic where they were accessible to staff. It is amazing how many little things there are to consider if you want something like this to be helpful.

If you were advising an organization looking to engage in VBC for the first time, what would you suggest they do first?

A lot of it really comes down to infrastructure and support. Does the organization have the ability and the organizational will to support the providers in this effort? Providers should not be solely responsible for the success of these programs. You need to have some people who are funded to spend time thinking about how to implement these programs. You need to make sure your electronic health record platform is built out and, if not, to ensure you have the ability and the will to make those changes. A lot of what we've done has been the Epic build. You

also need to have the data analytics support to report back to the providers regularly about their performance.

We were able to build our team through investments from Meaningful Use[4] and the PQRS program. We run on a shoestring, but we invest that shoestring. When we first engaged in the CMS Value Modifier program[5] and we had to report all those measures, we talked to people around the country who were hiring as many as 300 coders to go through and pull data from the charts. We had one analyst, and he was able to figure out how to pull the data from the electronic health record. We've had multiple value-based opportunities come to us, but we have rejected some — either because they just didn't fit with the models that we currently have or the data modeling did not suggest that we would be able to financially support the program. You must have the infrastructure for doing that kind of work, and it does take an investment. Organizations need to be cognizant that it is a heavy lift, but it is worth the time and effort to do it in a way that is meaningful to providers and improves patients' experiences.

Notes

1. The Employee Retirement Income Security Act of 1974 (ERISA) sets minimum standards for voluntarily established health plans in private industry to provide protection for individuals in these plans. Many of these plans are self-funded and exempt from state regulations. Refer to dol.gov/general/topic/health-plans/erisa.

2. The Physician Quality Reporting System (PQRS) was a voluntary reporting program that provided a financial incentive for clinicians who participated in Medicare to submit data on specified quality measures. The PQRS quality measures became part of the Merit-based Incentive Payment System (MIPS) in 2017. Refer to cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/TransitionResources_Landscape.pdf.

3. The Patient Health Questionnaire-9 Screening is used by providers to identify patients who may be suffering from or are at risk for major depressive disorder. Refer to ncbi.nlm.nih.gov/pmc/articles/PMC1495268.

4. Meaningful Use leveraged certified electronic health record technology for multiple purposes to improve quality, engage patients, improve care coordination, and maintain privacy and security. The Advancing Care Information category of MIPS now supplants Meaningful Use. Refer to healthit.gov/topic/meaningful-use-and-macra/meaningful-use.

5. The CMS Value Modifier program provided for an adjustment to payments under the physician fee schedule based on the quality of care. It has since been replaced by the Merit-based Incentive Payment System (MIPS). Refer to cms.gov/medicare/medicare-fee-for-service-payment/physicianfeedbackprogram.

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