RAPID PRACTICE INNOVATION

DATE: **PRACTICE:**

RECEPTIONIST

PHONES:

❑ Live ❑ Automated

APPOINTMENTS:

➲ New Patient _____

➲ Est Patient _____

➲ CPX _____

➲ Same Day _____

MESSAGES:

❑ Voicemail ❑ Written

❑ Electronic

_____

Team Member Interviewed

PROVIDER

DOCUMENTATION

❑ Paper ❑ EHR ❑ Scribe

MEDICATION:

❑ Generics

HOSPITAL:

❑ Admit Patients

❑ Use Hospitalists

❑ Receive Admit Notice

❑ Receive Discharge Notice

CARE MANGEMENT

❑ Pre-Diabetes: _____

❑ Diabetes: _____

❑ PT/INR ❑ Skin Biopsies

_____

Team Member Interviewed

CODING / BILLING

❑ Self (in-house) ❑ Company

CERTIFICATION:

❑ AAPC ❑ AHIMA ❑ None

CLAIMS:

➲ Avg. # ICD-10 _____

➲ Avg. # CPT _____

➲ Avg. # CPT II _____

PREVIOUS 2 WEEK TOTALS:

➲ Encounters:_____

➲ Claims Filed: _____

➲ Rejections: _____

➲ Denials: _____

_____

Team Member Interviewed

CHECK IN

SCHEDULING:

❑ Template ❑ Open

➲ Apt. Time _____

INSURANCE:

❑ Verified at Scheduling

❑ Verified Day Before

❑ Verified at Check In

❑ No Verification

WAITING:

➲ Wait Time _____

_____

Team Member Interviewed

CHECK OUT

SCHEDULE FOLLOW UP:

❑ Always ❑ Sometimes

❑ Rarely ❑ Never

SPECIALIST APPOINTMENTS:

❑ Office Schedules ❑ Patient Schedules

LABS AND DIAGNOSTIC TESTS:

❑ Office Schedules ❑ Patient Schedules

PATIENT COMPLAINTS:

➲ Last Week _____

_____

Team Member Interviewed

MEDICAL RECORDS

NEW PATIENT:

❑ Always ❑ Sometimes

❑ Rarely ❑ Never

HOSPITAL FOLLOW UP:

❑ Always ❑ Sometimes

❑ Rarely ❑ Never

CHANGING PROVIDER:

➲ Requests Last Week: _____

➲ Requests Last Month: _____

➲ Why? _____

_____

Team Member Interviewed

MEDICAL ASSISSTANT

CERTIFIED: ❑ Yes ❑ No

CLINICAL PRACTICE:

Annual CPX ❑ Yes ❑ No

Diabetic ❑ Yes ❑ No

Foot Checks: ❑ Yes ❑ No

Target Hgb A1c: _____

INJ: ❑ Flu ❑ Pneumo

_____

Team Member Interviewed

REFERRALS

➲ Average Wait time _____

NOTIFICATION:

❑ Phone ❑ Mail ❑ Appt.

FOLLOW UP:

❑ Apt. Scheduled / Documented

❑ Records Requested

❑ PCP Follow Up

PATIENT COMPLAINTS:

➲ Last Week _____

_____

Team Member Interviewed

OFFICE MANAGER

POLICIES:

❑ Same Day Appointments

❑ Returning Messages

❑ Medication Refills

❑ Hospital Follow Up

❑ ER Follow Up

❑ Missed Appointments

FOR THE LAST 2 WEEKS:

➲ Total # of Canceled : _____

➲ Total # of No-Shows: _____

_____

Team Member Interviewed

RAPID PRACTICE INNOVATION

OBSERVATIONS

❑ Monday ❑ Tuesday ❑ Wednesday ❑ Thursday ❑ Friday ❑ Morning ❑ Afternoon

Start Time: _____ End Time: _____ **Location:** ❑ Waiting Room ❑ Front Office

CYCLE TIMES:

PATIENT	SIGN-IN	CALLED BACK	CHECK OUT	TOTAL TIME
#1				
#2				
#3				
#4				
#5				

REPS:

Total Number of Reps at Window: _____ Total Number in Office: _____

❑ Monday ❑ Tuesday ❑ Wednesday ❑ Thursday ❑ Friday ❑ Morning ❑ Afternoon

Start Time: _____ End Time: _____ **Location:** ❑ Waiting Room ❑ Front Office

CYCLE TIMES:

PATIENT	SIGN-IN	CALLED BACK	CHECK OUT	TOTAL TIME
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#5				

REPS:

Total Number of Reps at Window: _____ Total Number in Office: _____

RAPID PLAN INNOVATION

Start-Up / Expansion
(ACO,MSO or IPA)

STEP ONE — Tear Down the Silos and Build Bridges

❑ **Re-Purpose** or **Hire**

- ➲ 20 to 1 ratio
- ➲ Medical or sales background
- ➲ Up-train (claims analyst, coding)
- ➲ Full access to membership, claims and pharmacy data
- ➲ Reports to senior executive with power to implement change
- ➲ Single point of contact

❑ **Build Relationships**

- ➲ Meet with office manager monthly
- ➲ Identify specific financial & utilization metrics
- ➲ Create a monthly report to share during regular meetings
- ➲ Hand deliver capitation check with member roster
- ➲ Solve problems

STEP TWO — Identify High Value and Low Value Practices

❑ **High Value**

- ✓ Aggressive management of diabetes and pre-diabetes
- ✓ Aggressive management of hypertension and hyperlipidemia
- ✓ Consistently sees hospital d/c within 72 hours
- ✓ Annual physical exams on all patients
- ✓ Focus on Prevention
- ✓ Same day appointments

❑ **Low Value**

- × Refers to endocrinologist for diabetic management
- × Minimal management of hypertension and hyperlipidemia
- × Rarely sees hospital d/c within 72 hours
- × Chronic care only
- × Name brand drugs

STEP THREE — Partner with the Champions

❑ **Key Metrics**

- ✓ PMPM expenses
- ✓ Bed days
- ✓ Readmission rates
- ✓ ER visits
- ✓ Generic dispensing rate
- ✓ % of LDL under 100
- ✓ % of annual exams
- ✓ Growth and retention
- ✓ Utilization expenses (specialists PMPM)

❑ **Key Behaviors**

- ✓ Easy to contract
- ✓ Easy to schedule
- ✓ Open notes
- ✓ Willing to learn
- ✓ Takes advantage of opportunities
- ✓ Business minded
- ✓ Long term relationships
- ✓ Good medicine trumps all

STEP FOUR — Eliminate the Weak Links

❑ **Monitor**

6 – 9 months

- ➲ Track and measure key metrics and behaviors.
- ➲ Document monthly meetings with focus on improvement and engagement.

❑ **Identify Outliers**

- ➲ Lowest performing practices and providers
- ➲ Hard to access with low engagement

❑ **Corrective Action Plans** 15-20 % reduction

- ➲ Shift membership to high value partners

STEP FIVE — Continuous Improvement Plan

❑ **Audit**

- ➲ 5-10 charts per provider
- ➲ Look at the "whole" picture
- ➲ Give actionable feedback
- ➲ Set a time for follow up audit
- ➲ Fix the problems that can be fixed – think long term…

❑ **Educate**

- ➲ Frontline – Lunch and Learn
  – Tools / Coding Aids
- ➲ Providers – Quarterly dinner meetings
  – Annual group education
  – Practice Support

STEP SIX — Invest in Your Members

❑ **Health Literacy**

- ➲ How does the health literacy of your population effect cost per claim?

❑ **Service Excellence**

- ➲ How do past experiences of care influence future decisions to seek care?
- ➲ What can we do to improve this experience?

❑ **Health Promotion**

- ➲ How can you partner with champions to promote wellness through community outreach?

RAPID PLAN INNOVATION

Value Based Insurance Design

VBID is a 5 year program to test whether higher quality and more cost-efficient care is achieved.

STEP ONE Identify or Review Program and Intervention

CY 2017

- ❑ Arizona
- ❑ Indiana
- ❑ Iowa
- ❑ Massachusetts
- ❑ Oregon
- ❑ Pennsylvania
- ❑ Tennessee

CY 2018

- ❑ Alabama
- ❑ Michigan
- ❑ Texas

*Starts in 2018 **Community, Non-dual, Aged

Targeted Condition	HCC	Coefficient**
Diabetes	17,18,19	0.104 – 0.318
CHF	85	0.323
COPD	111,112,114	0.209 – 0.599
Past Stroke	100	0.263
HTN	None	0
CAD	86,87,88	0.140 – 0.233
Mood Dis.	58	0.395
RA*	40	0.423
Dementia*	None	0

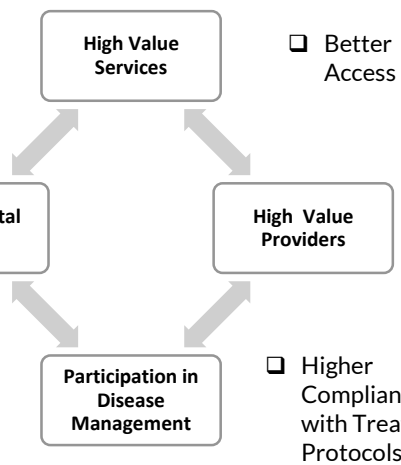
STEP TWO Estimate the Savings

The Assessment Should Include:

- ➲ Administration (offering different benefits for members in the same plan)
- ➲ Cost drivers for each targeted condition
- ➲ Coding Accuracy
- ➲ Impact of lost cost-sharing revenue
- ➲ Opportunities for intervention (services for which cost sharing should be eliminated or reduced
- ➲ Opportunities for savings through improved provider access or provider steerage
- ➲ Subsidies between targeted and non-targeted populations
- ➲ Sustainability

STEP THREE Educate Members and Providers

- ❑ Lower Cost Sharing
- ❑ Better Access
- ❑ Clinically Targeted Supplemental Benefits
- ❑ Higher Compliance with Treatment Protocols

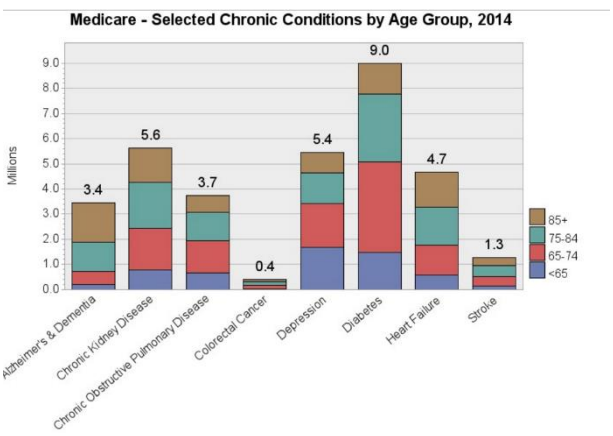


STEP FOUR Implement Program

The 9 Components of the Diabetes System of Care

Bundle Element	Quality Standard	Measure Type
Hgb A1c Measurement	Every 3 months	Process
Hgb A1c Control – Pt. Specific	7 – 8%	Clinical
LDL Measurement	Annually	Process
LDL Control	Under 100	Clinical
BP Measurement	Target – 140/80	Process
Micro Albumin	Annually	Process
Influenza	Annually	Process
Pneumococcal Imm	Once before 65 Once after 65	Process
Smoking Status Assessment	Non Smoker	Clinical

STEP FIVE Validated Coding / Documentation



STEP SIX Measure Value

Data Sources:

- ❑ Administrative Claims Data
- ❑ Program Data
- ❑ Clinical Data
- ❑ Patient Surveys

Measure Type:

- ✓ Allow Apple Time For Data Collection.
- ❑ Standardized
- ❑ Structure
- ❑ Process
- ❑ Clinical
- ❑ Outcome
- ❑ Long Term
- ❑ Patient Behavior Indicators