



# QUALITY CONNECTIONS

University of Maryland Quality Care Network Newsletter



## MAKING A DIFFERENCE

*"Case Management Team Goes Above and Beyond for Their Patients"*



### A Patient Story

Recently, a patient was referred to the Quality Care Network (QCN) Nurse Case Manager, Erin Boyle. The patient's primary care physician (PCP) was concerned about his Hemoglobin A1C of 15 and daily blood sugars that averaged between 300 and 500. His diet consisted of donuts, cookies, ice cream, and cake with minimal fruit and vegetable intake. He was unable to walk down aisles at the grocery store due to hip and leg pain. His orthopedic surgeon was unwilling to perform a hip replacement until his A1C was below 7.5.

### Patient Barriers

- Pain
- Lack of Motivation / Depression
- Consistent Support / Accountability
- Knowledge Deficit



Erin Boyle

### Interventions

Erin obtained a referral to the Center for Diabetes and Endocrinology, but he was unable to attend due to the high cost of the program. She sent him the Cornerstones4care books, coupons for diabetic Glucerna shakes, and the pamphlet for Dial-a-dietician. Erin discussed the importance of adhering to the ADA diet with him and his wife. Frequently addressing challenges, together they celebrated small victories such as setting a goal to check his blood sugar at least 3 times per week. Erin referred him to a health coach under the direction of Pack Health, for additional support. His wife retired earlier this year and was instrumental in encouraging behavior changes and reinforcing the importance of controlling his blood sugar.

### The Outcomes

- Checking blood sugar twice a day
- A1C down from 15 to 7.5 and healthy weight of 165
- Following ADA diet and eating more fruits and vegetables
- Drinking more water, only occasional snacks in the middle of the night
- Mowing the lawn, gardening, able to walk through the grocery store
- Able to have cataract surgery now that his blood sugars are below 200
- Hip replacement is on hold because he is not experiencing pain

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UNIVERSITY of MARYLAND  
QUALITY CARE  
NETWORK

# COVER STORY

Care Management Fees				
Risk Tier	Track 1		Track 2	
	Criteria	PBPM CMF	Criteria	PBPM CMF
Tier 1	01-24% HCC	\$6	01-24% HCC	\$9
Tier 2	25-49% HCC	\$8	25-49% HCC	\$11
Tier 3	50-74% HCC	\$16	50-74% HCC	\$19
Tier 4	75-89% HCC	\$30	75-89% HCC	\$33
	90+ HCC or persistent and severe mental illness, substance use disorder or dementia	\$50	90+ HCC or persistent and severe mental illness, substance use disorder or dementia	\$100

## RISK ADJUSTMENT

### What is risk adjustment?

The purpose for the Centers for Medicare and Medicaid Services (CMS) to conduct Risk adjustment is to pay plans for the risk of the beneficiaries they enroll, instead of calculating an average amount of total cost for all Medicare/Medicare Advantage beneficiaries. The CMS-HCC (Hierarchical Condition Categories) model incorporates risk adjustments based on demographics, chronic disease burden, disease interactions and diagnostic resources. In addition to diagnoses, base year factors include Medicaid status (defined as having at least one month of Medicaid eligibility during the base year), as well as gender, aged/disabled status, and whether a beneficiary lives in the community or in an institution.

### Why is risk adjustment important?

The CMS-HCC risk adjustment model is prospective: it uses health status in a “base year” to predict health care outcomes and costs in the following year.

For Maryland Primary Care Program (MDPCP), it is important to accurately document the underlying health status of patient populations in order to predict health care outcomes and costs. Risk adjustment is an important component of the MDPCP, as care management fees distributed to providers are based on patient risk scores based on HCC risk adjustment model.

For MSSP ACOs, higher risk scores for a population translate into a higher benchmark for expenditures, while lower risk scores translate into a lower benchmark. Having an accurate benchmark is vital in achieving shared savings. A benchmark that inadequately reflects the underlying health status of a population will be too low and will lead to expenditures that are higher than expected.

### Why is documentation & coding important relative to risk adjustment?

All risk adjustment models depend on complete and accurate reporting of patient data. CMS requires that a qualified healthcare provider identify all chronic conditions and severe diagnoses for each patient, to substantiate a “base year” health profile for those individuals.



**Monthly Payment is \$1678 less in 2017 as compared to 2016 and amounts to \$20,000 less in Annual payment**



<p>In 2016, Joanne, a 78 year old female, saw her primary care physician twice <u>and</u> her cardiologist once. Physicians documented a total of <b>six (6) diagnoses</b></p> <ol style="list-style-type: none"> <li>Diabetes w/retinopathy (HCC 18, relative factor of 0.368)</li> <li>Morbid obesity (HCC 22, relative factor of 0.365)</li> <li>Rheumatoid arthritis (HCC 40, relative factor of 0.374)</li> <li>CHF (HCC 85, relative factor of 0.368)</li> <li>Abdominal aortic aneurysm without rupture (HCC 107, relative factor of 0.299)</li> <li>COPD (HCC 111, relative factor of 0.346)</li> </ol> <p><b>2016 RAF Score: 2.998</b> Demographic score + HCC Interaction Scores for CHF &amp; COPD + HCC Interaction Scores for CHF &amp; Diabetes + RAF scores for 6 DX = 0.437 + 0.259 + 0.182 + 0.368 + 0.365 + 0.374 + 0.368 + 0.299 + 0.346 <b>Avg PMPM for MA Plan \$800</b> <b>Monthly Payment for Patient \$800*2.998 = \$2398</b></p>	<p>In 2017, Joanne saw her primary care physician only once and did not see her cardiologist. PCP documented <b>three (3) diagnoses</b></p> <ol style="list-style-type: none"> <li>Diabetes without complications (HCC 19, relative factor of 0.118)</li> <li>Obesity (unlike morbid obesity, not an HCC under the CMS model)</li> <li>COPD (HCC 111, relative factor of 0.346)</li> </ol> <p><b>2017 RAF Score: 0.901</b> Demographic Score + HCC Score of Diabetes without complications + COPD = 0.437 + 0.118 + 0.346 <b>Avg PMPM for MA Plan \$800</b> <b>Monthly Payment for Patient \$800*0.901 = \$720.80</b></p>
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## PRACTICE TRANSFORMATION

### NINE C'S PLAYBOOK

The Nine C's Playbook simplifies the transition from volume-based to value-based care while also embracing the Triple Aim Plus One: population health, per-capita cost, patient experience, and physician engagement. Implementation of the playbook can help improve the health care experience of both care teams and patients. Patients gain better access to care, more time with their provider, and less risk of unnecessary procedures.

Care teams gain a population health management tool that details successful processes, workflows, and behavioral approaches for high-risk patient identification, patient outreach to close gaps in care, care management, documentation and coding improvement, and performance monitoring. Practices can identify data trends on their population to highlight the areas in need of the greatest improvement, and utilize the Nine C's to build out role definitions, workflow tactics, and operational timelines to achieve improvement in the designated areas.

Please reach out to your practice transformation specialist for more information on how to implement the Nine C's Playbook in your practice.

### PRACTICE LUNCH & LEARNS

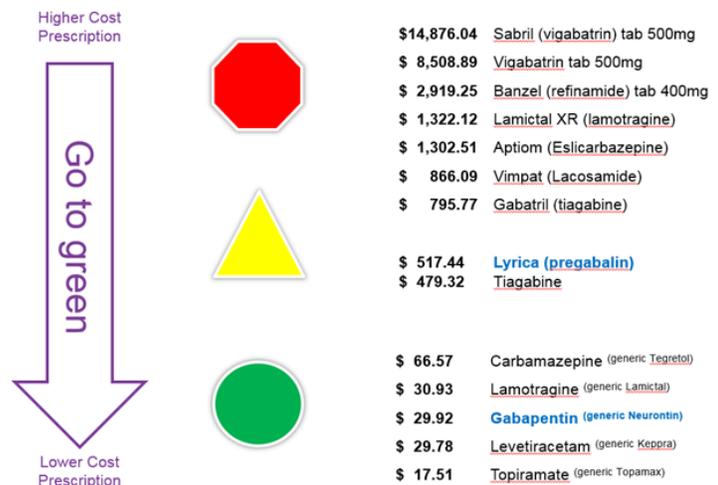
Upcoming topics are listed below, along with date and speaker. Past recordings are available upon request. All groups are encouraged to participate!

TOPIC	PRESENTER	DATE
PATIENT SATISFACTION/PATIENT FAC	Pranali Trivedi	9/20/2018
PHARMACY/MEDICINE MANAGEMENT	Danielle Keeley	10/4/2018



## COST & UTILIZATION

### NERVE PAIN AND ANTICONVULSANT PRESCRIPTION DRUG COSTS



## SERVICES

### UM QUALITY CARE NETWORK PARTNERS WITH PACK HEALTH

The UM Quality Care Network (UM QCN) is partnering with Pack Health, a digital health coaching company, to harness the power of everyday objects to meaningfully impact patients' health. One of the challenges of treating patients with chronic diseases has been providing ongoing support that extends beyond time spent with their physician. Pack Health specializes in engaging patients between clinic visits through a personalized approach, including phone calls, email, texts, and digital content. Patients enrolled in the Pack Health program will work weekly with a dedicated health advisor on identifying and working towards personal health goals. Weekly coaching sessions and personalized follow-ups, either online or over the phone, are scheduled based on the member's communication preference. In addition to being a virtual partner in problem-solving, coaches share videos, activities, and resources to support the member's specific health needs.

**The UM QCN goal is set to enroll a total of 1,000 patients in the Pack Health program.** Patients enrolled in the program will have up to a year from the enrollment date to engage with their health advisor. The UM QCN will work with individual practices to assess eligible patients as a benchmark target for this initiative. These include:

- UM QCN attributed Medicare/Medicare Advantage patients
- Type 2 Diabetes, Chronic Heart Failure, Chronic Obstructive Pulmonary Disease and Hypertension patients
- Patients with consistent access to a mobile or home phone
- English-speaking patients 18 years of age or older
- Patients willing to engage on a weekly basis with a health advisor

Enrolling patients in the program is easy. **Each patient enrolled in Pack Health will be assigned a UM QCN case manager, social worker, and pharmacist contact for escalation, who will engage members of the care team for the following types of issues or events:**

- Inpatient admission or ED visit
- Positive depression screening or suicide risk
- Adverse medical event
- Medication management issue
- Complex care coordination and care access issues
- One or more chronic conditions

## QUALITY

### UM QCN ACHIEVES EXCEPTIONAL PERFORMANCE INCENTIVE FOR PY2017

This summer, CMS released final MIPS scores. We are pleased to share that UM QCN achieved a final MIPS score of 93 points, resulting in a +1.65% increase to physician fee schedule across all participating groups. This has an estimated total value of about \$528,000 in addition to current fee for service revenue (based on an estimated QCN Medicare collections of \$32,000,000). The positive payment adjustment is effective as of Jan 1, 2019.

#### The Final Score At A Glance



## COMMUNITY HEALTH EVENTS

### UNIVERSITY OF MARYLAND 2018-2019 COMMUNITY HEALTH EVENTS

Below is a list of the community health events that are being offered by UMMS. If you would like to participate, please register by calling the phone number provided or by visiting the University of Maryland Medical System website. Health screenings, smoking cessation, support groups, and family programs are currently available for registration.

#### Upper Chesapeake Diabetes Prevention Program

16 weekly sessions facilitated by trained lifestyle coaches trained to help you learn how to lose weight, eat healthier, increase physical activity, and manage stress. CDC-approved content and participant guidebook included. Call 800-515-0044 for more details and registration.

- August 30 - December 27, 2018 (Thursdays)  
1:30 p.m. - 2:30 p.m.  
UM Upper Chesapeake Medical Center, Pavilion II  
Room 513, 510 Upper Chesapeake Drive, Bel Air, MD  
21014
- October 11 - January 31, 2019 (Thursdays)  
1:30 p.m. - 2:30 p.m.  
Highland Senior Center, 708 Highland Road, Street,  
MD 21154
- February 26 - June 11, 2019 (Tuesdays)  
6:00 p.m. - 7:00 p.m.  
UM Upper Chesapeake Medical Center, Pavilion II  
Room 513, 510 Upper Chesapeake Drive, Bel Air, MD  
21014
- March 4 - July 1, 2019 (Mondays)  
10:00 a.m. - 11:00 a.m.  
Harford Community College, 401 Thomas Run Road,  
Bel Air, MD 21015

#### Overdose Response Program

Visit <https://overdoseresponseprogram.eventbrite.com>

#### Upper Chesapeake Tobacco Cessation Class

A **FREE** six-week series of classes offered for any tobacco users who want to quit. Nicotine patches, lozenges, or gum may be available at no cost to those who qualify. Call Cancer LifeNet at 443-643-3350 for more details and registration.

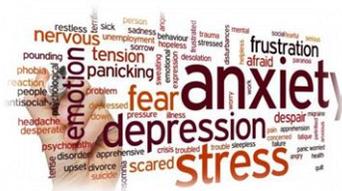
- Thursdays, September 6 - October 11, 2018; 6 p.m. - 7 p.m. at the Street Conference Center located at UM UCMC Kaufman Cancer Center.

#### Not All Wounds Are Visible: A Community Conversation

##### Let's Talk about Depression and Anxiety- Part II

##### Men, seniors, Chronic Disease and Suicide Prevention

Join the University of Maryland Medical System and the University of Maryland, Baltimore on Wednesday, November 28, 2018 from 9 am to 3 pm for a **FREE** community conversation about the impact of depression and anxiety on men, seniors, and those managing chronic disease. The important topic of suicide prevention will be also be discussed. Retired Baltimore Raven's running back and Super Bowl XXXV champion Jamal Lewis will be on hand to share lessons learned on his journey from stardom to falling into the shadows of public opinion, managing depression and thoughts of suicide to redefining himself after the "cheerleaders" in his life disappeared. This event is open to the public and provides an opportunity to hear from and talk to health care professionals and community leaders about depression and anxiety and the road to recovery. You will not want to miss this chance to ask questions and learn how to get help for yourself, family and friends, in your local community. Registration is strongly encouraged at [www.umms.org/community](http://www.umms.org/community). Join us for **FREE** discussions, breakfast, lunch, and resources.



## HEALTH & WELLNESS

### UNITED HEALTH CARE POLYPHARMACY CAMPAIGN

Polypharmacy, the simultaneous use of multiple medications in one patient to no one's surprise, can lead to many negative consequences. The use of multiple medications, not only increases health care costs, but can increase the risk of adverse drug events, drug interactions and medication non-adherence in patients. In an effort to reduce the risk of negative consequences associated with polypharmacy, United Health Care has identified a cohort of patients that are currently taking >10 medications.

Over the next three months, the UM QCN pharmacy team will be outreaching to the identified cohort to complete a comprehensive medication review telephonically. Each comprehensive medication review is completely voluntary. For those that do not return calls or decline to review their medications over the phone, a chart review of claims data and available EMR data will be completed. Upon the completion of each review, a pharmacy assessment will be completed and sent to the PCP's office for review. Please continue to be on the lookout for these comprehensive medication reviews and share program information with office staff.

Prospective organizations will receive informational materials. See the below links:

[National Second Quarter 2018 Direct Marketing Campaign Letter Package – "WIN-WIN"](#)

[National Handbook – "WIN-WIN / "Group Health Plans: Better for You, Better for Employees"](#)



### UNIVERSITY OF MARYLAND COPAY WAIVER PROGRAM

The University of Maryland Medical System (UMMS) Employee Health Network, in conjunction with the University of Maryland Quality Care Network (UM QCN), continues to offer a **health management program to their employees and spouses** that have been diagnosed with **diabetes and hypertension**. **This program is free, confidential, and voluntary**. In fact, participation will save the member money on most formulary medications for high blood pressure and diabetes, as well as diabetic supplies, by having their copays waived. Once enrolled, the beneficiary will engage telephonically with a UM QCN pharmacist throughout the year to help achieve and maintain good control over his/her diabetes and/or high blood pressure. **Members can enroll at any time during the year by calling 1-833-UMMS-QCN and referencing the Copay Waiver Program.**



### UNDERSTANDING PRACTICE TO MAKE IT EASIER TO GIVE GOOD CARE

What factors determine the decisions you make in practice? Dr. Dan Morgan with University of Maryland School of Medicine is now enrolling doctors, NPs, and PAs to take part in a study funded by a NIH Director's New Innovator Award that seeks to understand how clinical decisions are made in the face of uncertainty.

All participants who complete the 20 minute self-administered survey receive a \$50 Amazon e-Gift Card.

Contact the Research Coordinator, Sheila Staub, at [sstaub@som.umaryland.edu](mailto:sstaub@som.umaryland.edu) or 410-706-0090 for more information or to participate in the study; or Dr. Morgan at [dmorgan@som.umaryland.edu](mailto:dmorgan@som.umaryland.edu).

## MDPCP

### THE MARYLAND PRIMARY CARE PROGRAM

The Maryland Primary Care Program (MDPCP) is a voluntary program designed to help physicians transform their delivery of care from a fee for service model to one focused on value-based care. Modelled after the federal Comprehensive Primary Care Plus (CPC+) model, physicians aim to achieve care delivery objectives in five domains, including 1) Access and Continuity, 2) Care Management, 3) Comprehensiveness and Coordination, 4) Beneficiary and Caregiver Engagement, and 5) Planned Care for Health Outcomes. The program is set to launch on January 1, 2019.

Physician groups that submitted an application to participate in MDPCP can expect to receive notification of their selection status in October or November. Once practices have been selected, they will be expected to sign participation agreements with the Centers for Medicare & Medicaid Services (CMS) and their matched CTO, if applicable. In preparation for the program launch, we encourage you to review existing resources, such as the [Maryland Primary Care Program website](#) and [CPC+ Implementation Guide](#). These resources will help you gain a better understanding of the program requirements and available best practices to implement the necessary care transformation initiatives.



While MDPCP is comprised of many components similar to CPC+, a unique aspect of the program is the addition of Care Transformation Organizations (CTOs), which are entities that assist physicians and physician groups to meet the program care transformation requirements by providing care management support and practice transformation resources. During the program application period, physician groups had the opportunity to partner with a CTO of their choice. The Quality Care Network is pleased to have been selected to participate in MDPCP as the CTO **Transform Health MD**.

At this time, we would like to thank all of our physician groups that have chosen to continue partnering with us through **Transform Health MD**. Although our name has slightly changed, our core values and dedicated staff remain unchanged. Our behavioral health, data, pharmacy, practice transformation, quality, social work, and operations teams look forward to working synergistically with our matched physician groups to implement care transformation initiatives that are tailored to their individual needs.

During the practice application period, our staff members worked closely with practices to communicate new program information and provide assistance completing their applications. As the program launch date nears, our physician groups can expect the same level of communication and assistance we have been providing.

We are excited for the launch of this innovative program. If you have any questions regarding MDPCP or the program timeline, please do not hesitate to reach out to us at [ummscto@umm.edu](mailto:ummscto@umm.edu).

## NEW STAFF



**Terri Poole**

**Practice Transformation Specialist**

Terri Poole has joined the UM Quality Care Network (UM QCN) as the practice transformation specialist for the CMG Shore Region and Calvert Internal Medicine. She has been an employee within UMMS for six years, starting with the system working in the practice at BW Women's Health where she was the clinical manager. Prior to joining UM QCN, she was a credentialed Epic trainer and support analyst for UM CMG. She received her certification in EpicCare Ambulatory build in March of this year. Terri has 24 years of direct patient care experience in Family Practice and OBGYN. She completed her clinical education while serving in the U.S. Army.



**Rebecca Brumbaugh**

**Practice Transformation Specialist**

Rebecca Brumbaugh is a practice transformation specialist working with providers in Harford County, who include Harford Primary Care, Upper Chesapeake, and four independent practices. Rebecca has previous experience with valued based care from working with CareFirst's Patient-Centered Medical Home program, where she worked directly with providers for three years. Rebecca has a Bachelor's degree in Health Policy and Administration from The Pennsylvania State University and is excited to continue working in health care with UM QCN.

## CONTACT US

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