**Q&A – Elevate 2022**

January Learning Forum

The Value Imperative

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# Staffing & Value Questions

## Q: How can we ensure staff get raises and if the VB model incorporates yearly raises?

* NACHC Team: Consider developing an incentive program for staff and providers where incentives are awarded if care teams meet certain quality measures or performance goals.

## Q: How do you define your team members?

* Resource: An Action Guide for formalizing Care Teams can be found using [this link](https://www.nachc.org/wp-content/uploads/2019/11/NACHC-VTF-Care-Teams-AG_November-2019.pdf).
* From the Elevate Community, Savolia: Care Teams at CCI Health Services includes Community Health Workers and RN Care Managers.

## Q: How can we change the value proposition and workflow without increasing staff frustration?

* NACHC Team: The Action Guide below describes the steps leadership can take to advance their organization toward value-based care, and how to include staff members in the process. For example, investing in QI training for staff and establishing processes for team communication.
* Resource: An Action Guide for Leadership’s Role in Transformation can be found [here](https://www.nachc.org/wp-content/uploads/2019/11/NACHC-VTF-Leadership-AG_November-2019.pdf).

## Q: How can we deal with providers struggling with documenting properly for quality measures?

* Kristie Bennardi, CEO, Keystone Rural Health: We have a patient flow that starts with a morning huddle directly from our population management software that informs the rooming staff and providers what gaps or risk coding needs to be completed. Our rooming staff of MAs and LPNs capture a lot of the documentation when they room the patient so that all that is left for the provider is to simply review.

## Q: How do you pay for your case managers before additional revenue from VBC?

* NACHC Team: Start small and consider building case managers into grant/award budgets. It may take time for a case manager to build a caseload and generate revenue through direct billing or VBC.

## Q: What is the recommended ratio of RN Case Managers to Providers?

* NACHC Team: The optimal ratio of care managers to providers or care managers to patients is dependent on the risk level/needs of the patients and the services that the care manager will be providing.
* Resource: A guide for implementing care management can be found [here](https://www.nachc.org/wp-content/uploads/2019/11/NACHC-VTF-Care-Management-AG_November-2019.pdf).

## Q: For uninsured patients, how do you cover staff costs to do initiatives for all pts at Keystone?

* Kristie Bennardi, CEO, Keystone Rural Health: The revenue and incentive payments we receive are used to care for all patients regardless of their insurance or lack of. We are less than 5% uninsured. We are approximately 40% Medicaid.

# Annual Wellness Visit Questions

## Q: Do RNs do or assist AWVs?

* Judith Gaudet, Systems of Care Director, Generations Family Health Center: Under CMS, RN's can conduct AWV under the direct supervision of a physician. This is ok for billing but the RN visits do not count toward Risk Adjustment for payer sources.

## Q: Has anyone deployed an effective campaign around annual wellness visits or any of the screenings?

* Resource: We encourage everyone to check out the MLN’s website for a comprehensive set of resources using [this link](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html).

# Empanelment Questions

## Q: Can you share tips for empanelment when there is a decent amount of provider turnover?

* Judith Gaudet, Systems of Care Director, Generations Family Health Center: We have secondary providers in our care teams. They see patients when the PCP is not able. When a provider leaves, we have a policy for exiting provider empanelment where the available provider first seeing a patient when the PCP leaves will maintain continuity until the replacement is in place. We send letters to patients so they are aware of the process and we have a panel code so when the new provider comes in they are transitioned over. We also have a provider change policy so if a patient finds the new provider is not a good fit, they complete a form and we contact them to determine which provider would be best to move them to.
* NACHC Team: Empanelment data can be used to help inform staffing decisions related to provider turnover, such was whether a replacement provider is needed to take over the patient panel or whether other health center provider(s) have the capacity to absorb the patient panel into their own.
	+ Start by determining the current panel size of your health center providers and considering how ‘reasonable’ each provider’s panel size is. There is no universal magic number for the best panel size, as it is dependent on schedule availability and the complexity of patients.
	+ Measures can be used to help determine the ‘reasonableness’ of a current panel size (see two resources below). Be sure your health center policies and procedures include processes for updating the PCP field within your EHR when a provider leaves or joins your health center, and always allow patients the opportunity to choose their PCP.
* Resource: [The Third Next Available (IHI)](http://www.ihi.org/resources/Pages/Measures/ThirdNextAvailableAppointment.aspx%20and%20continuity)
* Resource: [Care Team Member/Patient Continuity: Review of Schedule (IHI)](http://www.ihi.org/resources/Pages/Measures/TeamMemberPatientContinuityReviewofSchedule.aspx)

## Q: Can you share general guidelines regarding range of panel numbers for IM, FM, and Pediatrics?

* NACHC Team: Optimal panel size is provider specific and dependent on schedule availability, complexity of patients, and care team support.

## Q: Can patients submit a form to Mass Health to transition from you to an existing PCP or BH provider or to you from a different assigned provider?

* NEW Health Team: The challenge comes for patients who are disinterested in doing the work to have Mass Health re-assign them. A small group, but these tend to also be very high users of ER/Inpt care. Patients can request a change in PCP with MassHealth; however, the wait/hold times for phone calls are very long, so patients often never make the change. It would be helpful if we as the health center could make the change with only the patient's consent.

# EMR & Tools Questions

## Q: What tools can track and monitor patient health outcomes and care gaps?

* Kristie Bennardi, CEO, Keystone Rural Health: We use i2i and the Aledade app, along with our EHR, to monitor our measures and gaps. We print out a morning report after our huddles with this info to give to the appropriate clinical staff each day.
* Heather Pelletier, CEO, Fish River Rural Health: We use our EHR for a majority of our data collection and population health activities.
* From the Elevate community, Lorie: We use Azara for morning huddles to look at gaps, it has helped with our quality measures.

## Q: How to approach HHCC - Hierarchical condition category coding - for Risk Modeling in your EMR?

* NACHC Team: This is a great question. We currently don’t have resources to spotlight here, but hope to be able to address the topic at an upcoming learning forum.