MEDICAL DIRECTOR MEETING

August 3 2017

GROUP MEMBERS PRESENT: Louis Di Lillo, Jatin Dave, Barbara Downey, Linda Doucette, Harold Greenspan, Vinay Kumar, Dennis Markovitz, Denise Mayo, David Pickul, Marc Pifko, Roger Schutt, William Sheckman, Joseph Taylor,

WEBINAR: Bashir Bashiruddin**,** Barbara Chambers, Richard Daly, Ellyn Davis, Tristan Diaz, Robert Fraser, Savitha Gowda, William Medwid, Sarah Nuciforo, Christopher Perkins, Melissa Rose, Kenneth Shamir

TMP Staff: Nora Buckley, Laura Chaves, Matthew Chukwu, Jonathan Harding, Denise Kress, Laura Ludwig, Mary Mathieu, Sara Raposo, Brenda Voye Reardon, Maria-Carolina Ruiz, Lisa Sullivan

TOPIC	DISCUSSION/QUESTIONS	**QUESTIONS/ANSWERS/ACTION/ FOLLOW UP**	**WHO**
Review of June meeting	Tom Croswell, CEO, discussed regulatory challenges and how TMP is meeting them. Josh Orr described a new fraud scheme to get doctors to prescribe unneeded diabetic testing supplies and how to detect, avoid, and report them. Dawn Mahler et. al. help small group workshop on improving performance on the Silverlink proxy Star measures.	JH to survey attendees – how useful? Well received? Share with prescribers in your PO Your recommendations to improve the survey will be considered in the Survey Planning Project Team in the fall – including giving groups their own year over year performance. Please work on improving performance on these metrics.	

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	Steve Kozak, THP Director BH, described the support his department provides for managing inpatient mental health admissions whether a BH hospital is capitated or not.	Follow up presentation with more specifics as requested tentatively scheduled for September.	
Best Practices presentation: Matthew Chukwu Tine Christiensen Best Practices Summary	Tine and Matt presented their findings from their interviews with successful groups within TMP and working with other Health Plans. Their presentation materials included tables and charts that slot the different activities required for success into buckets. • Identify risk segments and create differentiated patient education and care management programs –well, rising risk and complex & frail– using multiple, integrated data sources and predictive engine/rules to improve health outcomes • Engage and educate patients according to risk and social determinants, using a multi-channel communications system, starting with an opt-out mind-set • Take a multi-pronged approach to care management, ranging from self-serve model to in-person care management. Target 20%+ of population for more intensive engagement; incorporate social support navigation and resources • Provide flexible access to care, after-hours triage/steerage with care delivery expanded into the home (remote monitoring, in-home services for the frail); strong clinical leadership and governance) • Plan/Provider collaboration to tightly manage referral circles and avoid costly leakage • Link Star measures to focus areas for patient outreach and drive preventive services; engage with Providers on mutually-agreed quality goals and F/U • Workflow and clinical encounter preparation to capture coding at POC, with built-in chart reviews and data reconciliation, supported by Provider Risk adjustment training programs and reporting • Performance reporting (financial and clinical) down to PCP level, based on real-time and retrospective, bi-directional data feeds, including physician and member		

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Key Barriers to Effective Value-Based Care	profiling • Multiple data sources that are not integrated into one system • No or limited population health and value based care engagement • Limited access/hours and ED avoidance management • No or limited patient engagement resources • Inadequate EMR functionality for point of care documentation and care coordination • No process or care management resources in place to support key programs (e.g., advanced illness and post-discharge follow up management) • No hospital/practice EMR access • Limited transition management • Lack of strong governance practices and coordination across IDNs; no PCP-level incentives • Providers act independently, no focus on steerage or utilization management • N/A • Lack of participation and involvement in chart reviews and coding at the point of care • Lack of centralized EMR system • Reluctance to invest in technology and other tools to support value based care • Technology limitations		
Key Strengths Exhibited by Successful Groups	• Strong, stable leadership team, invested in Value Based Care and Care Management, with effective governance practices in place • Accessible with flexible hours/same-day appointments and after-hours telephonic triage/steerage support • PCP- and Practice- level incentives or penalties tied to outcomes/quality (e.g. upside sharing) • Strong execution mentality (both RA & CM); CM embedded at Practice level; provide in-home Primary care for frailest members; get actionable data in front of PCP at POC (e.g. coding, screening gaps, warm hand-offs to CM)		

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Audience input	• PCP/member level analytics/reporting infrastructure, with reports broadly shared across group • Effective member engagement and outreach programs (e.g. automatic enrollment in care management with opt-out) • Coordinated multi-disciplinary care models for managing member care and transition of care along the CM spectrum (e.g. collaboration between social workers, health coaches, CM, PCP and SPC) • Tight referral network to manage utilization & cost Q: How different is Internal vs. External Care management ? Comment: Its all about the budget, and paying attention to each patient as it adds up to good utilization. Comment: A key success factor is if hospitals you work with have the same incentives as	A. While we haven't compared these subpopulations lately, in prior years there was little difference overall. There are successful and unsuccessful groups with TMP CM and with their own CM. What makes a difference is how integrated into practices the doctors allow the CMs to be. This integration can occur with TMP CM, and can be blocked within IDNs that provide CM for practices	

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	the groups. Comment: Best practice is to identify patients with high risk that are not coming nto the office. Q. How do we prioritize the list of key barriers? Where do we invest? What is the right level of input to different groups of members? .	Risk adjustment activities, if they are new, have the highest return, though that return is delayed 1-2 yrs. UM – IP v. OBS, LOS in DRG hospitals, SNF LOS has quicker payoff. CM can have payoff within months after members are enrolled. Practice transformation ultimately needed by has longer payback period.	
2017 Quality Profile June Edition	Dr. Harding reviewed the profiles that were sent out in June including comparative group performance on multiple HEDIS measures based on 2016 data as well as the non user lists through May. He asked if any groups did not receive their reports; one did and will be resent. If you are reading these minutes and don't have your group's report let us know ASAP. Reminder that some HEDIS measures are based on chart review of a sample across the	Ensure someone goes through those lists and brings in any remaining non users in the next few months. TMP will send refreshed non user lists in October for a final end of year push.	Medical Group Leaders PF

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	entire TMP population so we do not have data at the group level. These measures are: • BMI calculation recording in every primary care record each year • BP recording, and especially the last BP in the chart in any calendar year should be within control per guidelines • Medication reconciliation between discharge meds and OP meds, noting any changes, after IP or SNF admission.	Include these measures in your own quality initiatives for your groups. Install EMR reminders, for example.	Medical Group Quality Leaders
Group Turnaround Dr. Delillo and Stacey Keogh Challenges Initiatives	NEPHO Medical Director, 3 Medical Leaders PCPs assigned to PODs based on specialty and practice: Internal Medicine and FP PCP Cap HSF/MSF Risk Sharing • NEPHO earned surpluses under the commercial contracts but could not sustain consistent positive trends with TMP • Within both private practice and employed PCP cohort we have several small practices of one or two providers • Seven different EMR types within the NEPHO • Aging PCP workforce • Mild to moderate amount of PCP burnout • Weekly care transition meetings with Leaders o Pilot for more involvement with daily interventions by the NEPHO POD Medical Leader o 5% reduction in inpatient admits/1000 o 8% reduction in SNF admits/1000 o Based on the pilot results, it was estimated that these trends could reduce medical expenses by $600,000/year • Risk adjustment & coding :		

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	○ Best practices/processes ○ Analytics/reporting ○ Provider trainings ○ NEPHO has a vendor for coding improvement initiatives: ○ PAF/ASM ○ Retrospective review ○ Pre-visit planning ○ Education ○ NEPHO's RAF score increased from 1.15 to 1.19 • Incentives & Risk Sharing: sharing of surplus based on performance metrics: ○ Attendance at POD meetings ○ MWOV below target or lower than prior year ○ Chronic Condition Recapture rate > than target or higher than prior year ○ RAF Score greater than target or higher than prior year ○ Incentives for In Network referrals and ER utilization in Risk Sharing program • Out of Network referral management • Discharge and disposition notification		
Best Practices: Silverlink Survey Brian Parillo, Executive director, CRMA Peter Sheckman, Medical Director TMP at PCPO	1. Silverlink results discussed at NSHS, TMP medical directors and POD meetings – 5 STAR rating reminders discussed. 2. The 'Standard Work' generated by our 'LEAN' process – The Virginia Mason methodology – deals with almost all of the elements of the Silverlink Survey The MA's and Docs are much invested with the Virginia Mason 'style. 3. We follow-up all fractures per the report from TMP with reminders to the primary MD and with a request for a response: need to study and treat or not. 4. We have attempted to create good templates for the phone receptionists to		

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	use regarding calls for appointments: green – fit them in directly; yellow – ask the MA ; and Red – call to the MD. We have urgent care available at the Lynn site and the COC or Mass. General North of the NSPG.		

September Agenda:
Behavioral Health Inpatient Management [introduced in June]
Claims Dispute Process
Winning at AEP
Wellness Visit reminder