MEDICAL DIRECTOR MEETING – MINUTES
February 2, 2017

GROUP MEMBERS PRESENT: Alan Abrams, MD; John Barravecchio, MD; Emily Chin, MD; Jatin Dave, MD; Linda Doucette, Barbara Downey; Leonard Finn, MD; Savitha Gowda, MD; Harold Greenspan, MD; Cynthia Roenberg, MD; Sheila Rozumek, MD; Shah Pramodchandra, MD; Peter Sheckman, MD; Joseph Taylor, MD; Tina Waugh, MD

WEBINAR: Robert Fraser, MD; Laura Ludwig; Shawn Pawson, MD; Douglas Gronda, MD; Sarah Nuciforo, MD; Shawn Pawson, MD; Kenneth Shamir, MD; Andrew Sharpin; Christine Lens; Ellyn Davis; Mary Mathieu; Rosa O'Campo; David Grace, MD

TOPIC	DISCUSSION/QUESTIONS	**QUESTIONS/ANSWERS/ACTION/ FOLLOW UP**	**WHO**
1. Review of January Meeting Jonathan Harding, MD	Annual Review of New Codes for Inclusion in PCP Capitation List . • 2nd page of new codes all agreed to be added to PCP cap list. • No consensus on SNF rounding codes. 2018 Benefit Considerations • Discussed whether adding a routine OOA benefit requiring referrals and managed by groups, to attract more mobile potential TMP members • Discussed adding cost share to Part B drugs rendered at the doctor's office, facility, or pharmacy: What cost share limits would you be willing to see applied to the below Part B Drugs? What other considerations should be addressed as this benefit is assessed? GOLD Guidelines for COPD. • Updated for 2017 including training patients on inhaler use, use of OP pulmonary rehab, consideration of comorbidities including BH. Pulm rehab access not felt to be a barrier. Screening for anxiety and depression in COPD to be addressed by CM program enhancements but PCPs should also adopt these screens as part of their assessment of these members.	• Bring back more info to Feb meeting to decide on SNF rounding codes. • All other codes presented added to PCP list • Feedback provided to Product Dept. re: OOA benefit (not in group risk); Part B cost share (equivalent to competitors) • Please volunteer to participate in benefit design focus group • F/u presentation on observing inhaler use	JH Group medical leader-ship DM

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Increasing Known Prevalence of Chronic Conditions: Volume Discount Purchasing Opportunities for Diabetic
 	
Peripheral Neuropathy Testing
	• DPNCheck® Fast, accurate, quantitative test for neuropathy
	• Point-of-care test of sural nerve conduction
	• Standard biomarker for DPN
	• Sensitive and specific for DPN
	• Quantitative and entirely objective
	• Easy operation
	• 30-60 seconds per test, doesn't disrupt patient flow
	• Testing can be done by MAs, techs, RNs, NPs, etc.
	• Test Results Reports 2 parameters (conduction velocity & amplitude) with clear cut-offs for easy interpretation
	• Testing Candidates:
	  ○ Members with diabetes – especially those without a diagnosed complication yet
	  ○ Those at risk for other polyneuropathies such as chemotherapy, alcohol or other toxin induced neuropathies
	• Test Results Interpretation & Documentation
	  ○ Device reports 2 values on display:
	  ○ Conduction Velocity
	  ○ Amplitude
	  ○ Clearly defined normal limit cutoffs (5µV & 41m/s)
	  ○ Results are recorded in EMR or chart
	  ○ Optional PC data management software:
	  ○ Generate and print report (hard copy or pdf)
	  ○ Automatic comparison to normal limits and identification of longitudinal changes
	  ○ Archive data
		We recommend acquiring this testing capability in PCP practices.
		
		Screen high risk members for DPN if they have uncomplicated diabetes.
		
		Value in purchasing this equipment and billing for other populations (e.g., ACO)
		
		Could also have value in helping diagnose patients with symptoms.
		
		Let me know if you are interested in purchasing so I can determine if we have enough interest to negotiate volume purchasing discount.
			Group medical leader-ship
			
			JH

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<tr><th>TOPIC</th><th>DISCUSSION/QUESTIONS</th><th>QUESTIONS/ANSWERS/ACTION/ FOLLOW UP</th><th>WHO</th></tr>
<tr>
<td>Peripheral Vascular Disease Screening</td>
<td>

NCS waveforms and values provide detailed documentation of neuropathy status

DPN Check Price Structure

NC-stat DPNCheck Device: $1,000
Biosensors: $15.00* each (1 per patient)

Impact of DPN on Risk Assessment 2017 Model (National Average)
<table>
<tr><th></th><th>Monthly</th><th>Annual</th></tr>
<tr><td>2017 National Average Capitation Rate*</td><td>$765.44</td><td>$9,185.29</td></tr>
<tr><td>HCC Impact**</td><td></td><td></td></tr>
<tr><td>Diabetes with Chronic Complications - HCC18</td><td>0.318</td><td>0.318</td></tr>
<tr><td>Diabetes without Complication - HCC19</td><td>0.104</td><td>0.104</td></tr>
<tr><td>Increased HCC Weight with HCC18</td><td>0.214</td><td>0.214</td></tr>
<tr><td>Increased Payment with HCC18</td><td>$163.80</td><td>$1,965.65</td></tr>
</table>

QuantaFlo™ PAD Test: We showed a video demonstrating the value of making the diagnosis of PAD, even in asymptomatic patients who are being treated for CAD.

Decrease amputation rate
Increased adherence to statin therapy and diet
Exercise program

Easy to Use in Busy Offices & Clinics

No special training required to perform or interpret test
Results available to physician immediately
Secure HL7 compliant data storage and export, integrates with EMR

</td>
<td>DPNCheck has only purchase option: $1000 (-x%)+ $15/pt.

Which Semler option might you consider?

Purchase Quantiflo, training your staff

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Multiscreening Clinics	systems • Fast, Accurate Blood Flow Testing o Simple, 5 minute in-office test o Well-tolerated by members o Equal or greater accuracy than ordinary ABI tests • Clinical results show QuantaFlo is equal or superior to traditional ABI using Duplex scans as the gold standard* • QuantaFlo™ Clinical Study Results **Study methods:** o Prospective study comparing accuracy of QuantaFlo™ System (QF) to ABI using primarily duplex ultrasound to confirm the presence or absence of PAD. o IRB- approved multi-center, single arm, post market study including primary care and vascular specialty physicians. • **QuantaFlo™ System Status** o FDA 510k clearance for commercial sale o Used routinely every day in medical practices throughout the U.S. o Patented with other patents pending o FDA-cleared o Well tolerated by patients o Report interpretation includes severity • Semler: Flow Check Device or multi-organ testing service • Semler manufacture of the FlowCheck device but also provides equipment/tests for Neuropathy, Retinopathy, Osteoporosis, Spirometry, ECG, LABS and AWV. • WellChec is a nationwide service of Semler Scientific providing a turnkey solution for administering key clinical tests that can impact HCC classifications, CPT coding, HEDIS and Quality Measures. • Features of WellChec o can assist in patient test scheduling if desired o handle testing with trained personnel o reduce variable costs and expense uncertainty	• Lease option, training your staff • WellCheck Testing option with Quantiflo and other equipment, Neuropathy, Retinopathy, Osteoporosis, Spirometry, ECG, LABS with Semler staff doing the Both vendors have indicated volume discounts but have not specified them yet until I tell them how much volume. I need an estimate of participants first before I tell you the final price . Please e mail me via Maria if you are interested • Which equipment might you be interested in purchasing? • How many of each might you purchase?	

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	○ HCC RAF lifts up to 37% plus additional CPT coding opportunities ○ provide all applicable training and provide a certificate. ○ 24-hour tech support and extensive clinical support. ○ monitor all usage and have an analytics reporting package for you to understand the data. ○ We will work with all the groups to achieve success and acceptance. • Purchase/lease options: ○ On site testing package: we provide the equipment and staff member for on-site testing. Services are typically done with a per patient fee, based on personnel and tests that are chosen. We also have a scheduling, coding review package, if desired. ○ Equipment only option: costs are based on what you choose, we have annual and monthly contracts. Semler will recommend who to screen and how to begin a program. Risk factors including age groups, those with smoking history, diabetes, etc. Our goal is for you to test only those patients that need testing. We do not recommend unnecessary testing.		

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Follow-up to PCP Capitation List Topic		Decision was to exclude both the 2 new and the existing SNF rounding codes from the PCP capitation, reflecting a change in practice such that SNF rounding on one's own patients is extraordinary for PCPs in this environment.	JH/ MW

New Proc	Description
G9679	Onsite acute care treatment of a nursing facility resident with pneumonia. May only be billed once per day per beneficiary
G9680	Onsite acute care treatment of a nursing facility resident with CHF. May only be billed once per day per beneficiary
G9681	Onsite acute care treatment of a nursing facility resident with COPD or asthma. May only be billed once per day per beneficiary
G9682	Onsite acute care treatment of a nursing facility resident with a skin infection. May only be billed once per day per beneficiary
G9683	Onsite acute care treatment of a nursing facility resident with fluid or electrolyte disorder or dehydration (similar pattern). May only be billed once per day per beneficiary
G9684	Onsite acute care treatment of a nursing facility resident for a UTI. May only be billed once per day per beneficiary
G9685	Evaluation and management of a beneficiary's acute change in condition in a nursing facility

Procedure codes Presented at January Meeting Should We Add these NEW Procedure Codes to PCP Capitation List

Questions from January Meeting

1. Are G Codes Payable by FFS Medicare? Answer: Some Are:

- PAR AMOUNT NON-PAR AMOUNT
- G9685* $217.13 $206.27
- G9686** $84.25 $80.04

*Evaluation and management of a beneficiary's acute change in condition in a nursing facility

**Onsite nursing facility conference, that is separate and distinct from an Evaluation and Management visit, including qualified practitioner and at least one member of the nursing facility interdisciplinary care team

2. What existing SNF Rounding Codes are Currently in PCP Capitation List?

- Initial Nursing Facility Care - New or Established Patient 99304, 99305, 99306
- Subsequent Nursing Facility Care 99307, 99308, 99309, 99310

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	• About 69% of the SNF Visit activity performed by PCPs is accounted for by procedure codes 99308 and 99309.
	• Nursing Facility Discharge Services
	  o 99315 - Nursing facility discharge day management; 30 minutes or less
	  o 99316 - Nursing facility discharge day management; more than 30 minutes
	• Other Nursing Facility Services: 99318 - Evaluation and management of a patient involving an annual nursing facility assessment, which requires these 3 components: (1) a detailed interval history, (2) a comprehensive examination, (3) Medical decision making that is of low to moderate complexity.
	
	3. How much are the existing codes being used?
	Volume of PCP Provided SNF Visits Currently in PCP Capitation List
	Payment Type — Value of Services — Units
	Capitated — $ 367,387 — 4,265
	Fee-for-service* — $ 74,050 — 804
	Total — $ 441,437 — 5,069
	
	Some PCPs do not have a PCP cap		

Custom Care: New TMP Product AND Care Management Program	• Care Management: Is It Different? Goals and Objectives of Custom Care Interaction • Appropriately engage a population of members with chronic disease earlier in the progression of condition • Triage members into higher and lower touch models for longitudinal interaction • Support members in accessing and increasing provider visits • Educate members on resources and health and wellness programs • Coach to self-management techniques for disease management • Screening for functional declines or comorbid behavioral health conditions • Goals of Care discussion opportunity early and often VBID Eligible Population • Only 15% of members who meet benefit eligibility by diagnosis are	This presentation was informational. Details on the program have been shared with Care Management Leadership. Our ask of medical leadership is to support CM in this enhancement. One question frequently asked is the impact of this program on physician cash flow due to the change in benefit for reduced member co-payments. In short: For specialists, the reduced copayment means more direct payment from TMP;	Group Medical and CM leaders

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	currently enrolled in Care Management • Of those not enrolled in Care Management, 80% have never been identified for Care Management, 20% have history of being enrolled • 94% of the eligible population was identified by Outpatient criteria alone • 6% of the eligible was identified only by Admission or ER criteria datasets Care Management Tools and Approach • Increased enrollment in Care Management is expected • To ease the burden of the early year influx, reporting requirement for external groups was altered to give more time to report disposition on membership from 30 days to 60 days • Required assessment expansion to include disease specific to meet enrollment criteria • TMP has provided recommended tools such as the Vulnerable Elder Survey and will be providing the educational mailings to the Wellness population	no change in revenue. For non capitated PCPs, same as specialists For capitated PCPs, they will see a reduction in revenue from this benefit change. The hope and goal and plan is that HSF surplus will increase from better management of HF and COPD patients who drive admissions and especially readmissions, far more than the loss of PCP copayments.	

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Engagement Tiers

Complex/Chronic Management	Risk Management	Wellness Monitoring
Identified by Predictive Model or Ad Hoc Criteria	PAM Level = 1,2	PAM Level = 3, 4
✓ Current high touch integrated model ✓ Disease specific teaching and monitoring ✓ Home visit for most frail ✓ Transition to lower level of oversight when goals of intensive program met	✓ Quarterly Outreach by clinician ✓ Disease specific teaching ✓ CHF/COPD Assessment ✓ PHQ2 ✓ Educational Mailings ✓ Refer to Chronic Disease Self Management programs	✓ Quarterly Outreach by non-clinician/navigator resource* ✓ Vulnerable Elder Survey ✓ Educational mailings ✓ Encourage PCP and Specialist Visits **or clinician based on medical group preference and staffing*

- Custom Care Activity as of January 26th
- Auto-Enrolled Members who met eligibility and were already enrolled in Care Management on 1/1
  - 2,215 in Total
  - 13 have subsequently Opted-Out
- Eligible members have all received mailings in January
  - 10,741 in Total
  - 56 have Opted- Out (proactively, not required)
  - 439 have Opted – In
  - Additional 22 members have called in with questions without enrollment in benefit
- Custom Care/VBID Financial Projection
  Based on input from our provider network, our model's intervention should reduce barriers to receiving office-based care thereby reducing preventable utilization of ER/IP/SNF
- Intervention Design Requirement: improve member engagement and care without increasing costs

TUFTS Health Plan

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<tr><th>TOPIC</th><th>DISCUSSION/QUESTIONS</th><th>QUESTIONS/ANSWERS/ACTION/ FOLLOW UP</th><th>WHO</th></tr>
<tr><td></td><td>
• Custom Care/VBID Financial Projection
<table>
<tr><th>Service</th><th>Assumption</th><th>Estimated FFS impact - PMPM</th></tr>
<tr><td>PCP copay reduction</td><td>Decrease to $0</td><td>(.15 to.19)</td></tr>
<tr><td>PCP additional utilization</td><td>5% increase</td><td>(.07 to.09)</td></tr>
<tr><td>Specialist copay reduction</td><td>Decrease to PCP level (varies by product)</td><td>(.06 to.08)</td></tr>
<tr><td>Specialist additional utilization</td><td>5% increase</td><td>(.05 to.06)</td></tr>
<tr><td>Total Costs</td><td></td><td>(.33-.41)</td></tr>
<tr><td>Inpatient utilization</td><td>1.25% decrease</td><td>.47 to .57</td></tr>
<tr><td>SNF utilization</td><td>1.25% decrease</td><td>.05 to .07</td></tr>
<tr><td>ER utilization</td><td>1.25% decrease</td><td>.01</td></tr>
<tr><td>Total Savings</td><td></td><td>.53 to .65</td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td>Net Savings</td><td>Total HMO Population</td><td>.12 to .32</td></tr>
<tr><td></td><td>Custom Care Participants Only</td><td>2.18 to 5.55</td></tr>
</table>
</td><td></td><td></td></tr>
<tr><td>Proper Technique And Selection of Common Inhaler Devices</td><td>
Inhaler Devices
• There are 15+ types of inhaler devices on the US market
• The different types of inhaler devices are likely to be equally effective in delivering medication when used correctly
• Depending on the type of inhaler, 43% to 75% percent of patients may be using them correctly
• Improper technique often go unrecognized, as patients are not asked to demonstrate their inhaler technique to a health care provider
• There are nuances with each type of device
• About 60% of patients with COPD do not adhere to treatment due to lack of understanding medications and disease, medication costs, and insufficient provider instruction and follow-up
</td><td>
Direct practices to use these instructional videos when seeing COPD patients: http://www.copdfoundation.org/Learn-More /For-Patients-Caregivers/Educational-Video-Series/Inhaler-Training-Videos.aspx

Take Home Points
•When choosing an inhaler consider:
- Type of inhaler device and cost
- Dose frequency
- The availability of the desired
</td><td>Group Medical Leaders</td></tr>
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	• Metered-Dose Inhaler (MDI) • Soft-Mist Inhaler (Respimat) • Dry-Powder Inhaler (DPI): - *Diskus* - *Ellipta* - *Handihaler* - *Flexhaler* - *Diskhaler* - *Neohaler* - *Podhaler* - *Pressair* - *Respiclick* - *Twistihaler* Metered Dose Inhaler (MDI) ***Advair HFA*** *(*fluticasone/salmeterol) ***Atrovent HFA*** *(*ipratropium) ***Flovent HFA*** *(*fluticasone propionate) ***Proventil HFA*** *(*albuterol) ***QVAR*** *(*beclomethasone dipropionate) ***Symbicort*** *(*budesonide/formoterol) ***Ventolin HFA*** *(*albuterol) ***Xopenex HFA*** *(*levalbuterol) **Proair HFA** (albuterol) Metered-Dose Inhaler (MDI • <u>General steps for use</u> Shake the inhaler well. Prime before first use: 2 to 4 sprays OR If not used for more than 1 week <u>If using a spacer</u>: attach the spacer and the inhaler together, with the inhaler's canister in a vertical position Breathe out fully through the mouth, away from the inhaler o Put the mouthpiece in the mouth and tighten the lips around it o Press the canister down while inhaling **deeply and slowly** through the	medication in the desired device - Ability to use the device properly(cognition, dexterity, strength) - Preference (patients are more likely to use the device they prefer) •Inadequate inspiratory flow should be suspected in patients with very severe COPD or poor respiratory effort.[• DPIs may not be best for patients who cannot produce an adequate inspiratory flow rate • PIFR of greater than 60 L/min is considered ideal for use of most DPI devices • PIFR of less than 30 L/min may be insufficient for optimal pulmonary deposition • Use of spacer devices eliminate the need to coordinate inhalation with actuation with MDI inhalation technique Disseminate proper inhaler technique video link to your practices, and encourage them to train all members with COPD on inhalers, including observing the patient taking the inhaler.	

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	mouth o Hold the breath for as long as comfortably possible, generally up to ten seconds and then breathe out o Wait before repeating, usually 30 to 60 seconds • MDI- Common errors Shaking of the device, which disperses propellant for aerosolization **Most common-** failure to synchronize inhalation with MDI actuation (poor "hand–breath coordination") Allows medication particles of a respirable size to develop Holding the breath for at least six seconds after the inhalation to allow deposition of respirable particles in the airways **A study of 3800 patients found at least one of above critical steps was omitted in 76% of patient demonstrations** Soft-Mist Inhaler-Respimat • ***Combivent Respimat*** *(*albuterol/ipratropium), ***Spiriva Respimat*** *(*tiotropium), ***Spiriva Respimat*** *(*tiotropium) ***Striverdi Respimat*** *(*olodaterol) • General steps for use: o Hold the inhaler upright o Turn the base in the direction of the arrows until it clicks o Flip the cap until it snaps open o Breathe out fully through the mouth, away from the inhaler o Put the mouthpiece in the mouth and tighten the lips around the end without covering the air vents o Press the dose release button and inhale **deeply and slowly** through the mouth o Hold the breath as long as comfortably possible, up to ten seconds • Dry-Powder Inhaler (DPI): *Diskus* • ***Advair Diskus*** *(*fluticasone/salmeterol), ***Flovent Diskus*** *(*fluticasone), ***Serevent Diskus*** *(*salmeterol) • General steps for use:		

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	○ After opening the inhaler with the thumb grip, hold the inhaler flat and level, and slide the lever from left to right until it clicks ○ Breathe out fully through the mouth, away from the inhaler ○ Put the mouthpiece in the mouth and tighten the lips around it ○ Inhale **quickly and deeply** through the mouth ○ Remove the device from the mouth and hold the breath as long as comfortably possible, up to ten seconds • Dry-Powder Inhaler (DPI): *Ellipta* • ***Anoro Ellipta*** *(*umeclidinium/vilanterol), ***Arnuity Ellipta*** *(*fluticasone),***Incruse Ellipta** *(*umeclidinium),***Breo Ellipta** *(*fluticasone/vilanterol) • General steps for use: ○ Slide the inhaler cover down to reveal the mouthpiece ○ Breathe out fully through the mouth, away from the inhaler ○ Put the mouthpiece between the lips ○ Do not block the air vents with the fingers ○ Breathe in **deeply and slowly** through the mouth ○ Remove the inhaler from the mouth and hold the breath for three or four seconds or as long as comfortably possible • Dry-Powder Inhaler (DPI): *Handihaler* • **Spiriva Handihaler (tiotropium)** • General steps for use: ○ Remove the inhaler cap by pressing the piercing button ○ Expose the center chamber by pulling the mouthpiece up and away from its base ○ Place one capsule (removed from its foil blister) in the center chamber of the inhaler and close the mouthpiece until it clicks ○ Continue to hold the inhaler with the mouthpiece pointed up, press the button on the side once, then release it		

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	○ Breathe out fully through the mouth, away from the inhaler ○ Place the inhaler in a horizontal position and place the mouthpiece in the mouth, tightening the lips around it ○ Breathe in **deeply** through the mouth and hold the breath for a few seconds ○ Remove the mouthpiece from the mouth ○ Repeat the steps starting with "Breathe out fully through the mouth" a second time ○ Open the mouthpiece, remove the used capsule, and discard it • Spiriva Handihaler: Loading, puncturing, and discarding the capsule require some manual dexterity and strength, which may pose a problem for the elderly and patients with severe shortness of breath. **Consider Ellipta or Respimat** • Education and repetitive demonstration are key to proper inhaler technique • Encourage patients to bring handheld devices to appointments • Nebulization requires minimal cognitive abilities and no hand–breath coordination, manual dexterity, or hand strength • Combined use of a nebulizer and hand-held inhaler in the elderly may be favorable		

March Agenda

Accountability
Enforcing Referral Circles
10 Day report follow up
Buying screening equipment follow up
2016 Evaluation/2017 Topic suggestions follow up

Jonathan Harding, MD, Senior Medical Director, Senior Products, Tufts Health Plan