Case STUDY

Silver State ACO's Provider Engagement Strategy

This case study describes the strategy that the Silver State Accountable Care Organization (SSACO) developed to engage providers in quality improvement and increase its overall quality score. The ACO's quality improvement team produces monthly scorecards, either at the practice or clinician level, based on the needs of the practice. Quality coordinators meet with practices each month and with individual clinicians each quarter to discuss the scorecard results, identify opportunities to improve quality, and develop specific quality improvement plans. SSACO launched its provider feedback strategy in 2014. Since then, the ACO has seen substantial improvements on some key measures, with an overall quality score increase from 87.5 percent in 2015 to 90.2 percent in 2017.

OVERVIEW OF THE ACO

The Silver State Accountable Care Organization (SSACO) is a practice-led ACO composed of 44 independent physician practices in Nevada. The ACO joined Track 1 of the Medicare Shared Savings Program (MSSP) in 2014 with almost 15,000 aligned beneficiaries and grew to about 41,200 aligned beneficiaries by 2019. SSACO includes practices in urban, suburban, and rural areas. It currently has 470 primary care providers and three cardiology provider groups (the only type of specialty group participating in the ACO). SSACO's practices currently use 17 different electronic health record (EHR) systems.

BACKGROUND ON THE ACO'S QUALITY IMPROVEMENT STRATEGY

Soon after launching, SSACO identified an opportunity to improve its quality scores based on an examination of claims data and early quality measure results. The ACO concluded that practices were providing fall screenings and other valuable preventive care to beneficiaries but inconsistently completed the documentation for CMS quality data submissions. SSACO then contacted the practices to discuss strategies to improve documentation of preventive care services. Through these conversations, providers requested practice-level quality data to support their efforts to design quality improvement initiatives.

Initially, SSACO relied on data from medical records to generate its monthly, practice-level quality scorecards. The scorecard development process began with ACO staff manually auditing patient charts to identify documentation discrepancies related to the CMS ACO-specific quality measures and meaningful use standards. Over time, as the number of practices participating in the ACO grew and the intensity of scorecard production increased, SSACO hired additional staff for the quality improvement team. In addition, the quality improvement team also began engaging with practices in person to discuss the scorecard data and consider quality improvement strategies.

SSACO currently employs eight quality coordinators who produce, review, and deliver quality improvement scorecards to practices and providers. The quality coordinators look for

insights from these scorecards to develop templates that will support consistent documentation, define new improvement priorities in collaboration with practices, and identify opportunities to connect practices with external resources to address care gaps. Rhonda Hamilton, SSACO's Chief Operating Officer, and Lawrence Preston, SSACO's Chief Executive Officer, provide broad oversight of the quality improvement team and support implementation of the ACO's overall provider feedback strategy.

PROGRAM DESCRIPTION

SSACO's provider feedback strategy includes two components: (1) production of quality improvement scorecards and (2) hands-on support from a team of quality coordinators to identify strategies for further improvement. This case study explains how the quality coordinators develop and employ quality scorecards to engage providers and practices in meeting quality goals for the CMS Web Interface measures.[1]

Description of the quality improvement scorecards

SSACO delivers to its practices monthly scorecards that include actionable data to support their quality improvement efforts. Depending upon the preferences of the practice, SSACO may aggregate all metrics to the practice level or produce clinician-level scorecards. The scorecards contain 10 CMS Web Interface measures and 16 measures developed by SSACO that consider spending, utilization, and demographic data (see Table 1 for the list). For the CMS measures, the scorecard compares the practice or clinician's performance to the 90th percentile benchmarks established by CMS.

Table 1

Scorecard measures

Source	Category	Measure
CMS	Care coordination	Falls: Screening for Future Fall Risk (QI #318)
	Condition specific	• Depression Remission at 12 Months (QI #370) • Composite (All or Nothing Scoring): Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) (QI #001) • HTN-2 Controlling High Blood Pressure (#236)
	Preventive care	• Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (QI #226) • Preventive Care and Screening: Screening for Depression and Follow-Up Plan (QI #134) • Colorectal Cancer Screening (QI #113) • Breast Cancer Screening (QI #112) • Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (QI #438) • Preventive Care and Screening: Influenza Immunization (QI #110)
SSACO	Spending	• Overall year-to-date spending • Number of costly patients[a] • Number of patients in top 20% of ACO spending
	Utilization	• Number of AWV reports due • Percentage of AWVs completed • ED visits per 1,000 • ED visits leading to hospitalization per 1,000 • Inpatient discharges per 1,000 • Thirty-day readmission rate • CT scans per 1,000 • MRI events per 1,000 • Transitional care management visits per 1,000
	Demographics	• Average number of chronic conditions per patient • Top chronic condition • Number of frequent ED patients[b] • Average HCC Score for practice

[a]SSACO defines costly patients as those who had either (1) an HCC score in the top 30 percent for the ACO in the current or prior year, three or more chronic conditions, and two or more inpatient stays or (2) three or more ED visits in the past 24 months.
[b]SSACO defines frequent ED patients as those who have three or more ED visits in the past 12 months.
AWV = annual wellness visit; ED = emergency department; HCC = hierarchical condition category; QI = Quality ID (CMS).

[1] CMS Web Interface was formerly known as the Group Practice Reporting Option (or GPRO) Web Interface. CMS Web Interface is one of six data submission options under Merit-Based Incentive Payment System. See the Quality Payment Program Library (https://qpp.cms.gov/about/resource-library) for more information about Web Interface measure specification.

For all measures, the scorecard compares performance to the ACO average. Although there is no formal benchmark for the measures developed by SSACO, the ACO considers performance on those measures when making decisions about distributing shared savings.

SSACO hired a third-party vendor to create and maintain a data analytics system that synthesizes claims and data from SSACO manual chart audits to produce the scorecards. The quality coordinators choose the basic scorecard parameters (for example, provider or practice level) and measure inputs from a menu, then the analytics system exports the data. The coordinators format and print the scorecards for each practice and discuss them during their in-person meetings. Providers can also access their scorecards in an online platform to see their own score and the 90th percentile target based on CMS data. As shown in the example in Figure 1, SSACO uses the following icons to draw attention to improvement opportunities:

- Green checkmark, if the provider scored above the 90th percentile

- Yellow exclamation point, if the provider scored between the 90th and the 60th percentiles

- Red "x," if the provider scored below the 60th percentile

Quality coordinators support provider feedback strategy

SSACO quality coordinators use the scorecards as a starting point for engaging practices in quality improvement activities. Each quality coordinator is responsible for working with five to eight practices. To support the practices with their improvement efforts,

the quality coordinators carefully review the measure scores and spend time visiting each practice to establish relationships with providers and staff and to learn about the practice's culture.

> *"One of our strengths is being flexible and being able to adapt to what the practices need."*
>
> —Rhonda Hamilton, Chief Operating Officer

At a minimum, the quality coordinators meet in person with lead contacts at the practices monthly and with all of the practice's clinicians quarterly. For the monthly meetings, quality coordinators often meet with the lead physician; for some practices, they meet with the practice administrator or a contact at the corporate level. Given the challenges of scheduling a quarterly meeting that all of a site's clinicians can attend, the quality coordinators often attend practices' standing meetings and use those meetings as an opportunity to talk about quality improvement with the clinical staff.

The conversations focus on insights from the printed scorecards and approaches to continue to improve quality. For practices with a competitive culture, quality coordinators may also review individual clinician scorecards with the entire practice to provide additional learning opportunities and encouragement for the full group of clinicians. In these conversations, the quality coordinator may document next steps and improvement goals in detailed action plans, identify external resources and equipment

Figure 1

Example provider-level scorecard

2018 Quality Measures Detail Performance			
Measure	**Medicare Target**		**Completed Patients**
Care Coordination			
Falls: Screening for Future Fall Risk	91	(!)	90
Preventive Care			
Breast Cancer Screening	90	(!)	78
Influenza Immunization	90	(✓)	95
Screening for Depression and Follow-Up Plan	90	(✗)	59
Condition Specific Measures			
Diabetes Comp	60	(✗)	31
Controlling High Blood Pressure	90	(!)	78

Silver State ACO's provider-level score card lists performance for 14 quality measures. Figure 1 shows a subset of those measures as an example of how the information is displayed.

to further quality improvement, and create templates to help practices improve their documentation. "We found that the more feedback we can give [practices], the more they see our faces and know we're coming back to tell them how well they've improved or haven't, the better we do overall," Hamilton explained. After the meeting, quality coordinators connect with practices on an ongoing basis to monitor progress and provide further support. Figure 2 describes key steps in the quality coordinator's feedback process to engage a practice.

Figure 2

SSACO quality coordinator feedback process

Prepare data	Audit charts for documentation related to CMS Web Interface measures
	Schedule monthly practice meetings and quarterly clinician meetings
	Export and format practice-level scorecards
Support practices on-site	Deliver quality improvement action plans
	Create and disseminate templates for documentation
	Connect practices to external resources
Monitor progress	Audit charts to monitor action plan progress on a rolling basis
	Follow up with practice based on results shown in patient data

Establishing quality improvement goals by using action plans

The quality coordinators collaborate with the practices to create quarterly action plans that define their improvement goals, outline tasks in their improvement strategy, and specify next steps. SSACO provides the quality coordinators with a template to draft the action plans (see Figure 3 for an example)—encouraging them to focus on quality measures that scored below the CMS 90th percentile benchmark. The quality coordinators populate the action plans based on insights they gleaned from past conversations with the practices. The plans include a specific goal with a timeline for achieving the goal, strategies to undertake to meet the goal, and suggested tips. The coordinators then meet with practice staff and providers to discuss the proposed strategy in the action plan and make revisions as needed. At the conclusion of the meeting, the practice administrator and quality coordinator sign the action plan.

After establishing an action plan, the quality coordinator assesses a practice's progress by reviewing the medical records of patients who were seen after the plan was implemented and by auditing charts to ensure that the suggested actions were taken. In addition, the coordinator discusses the action plan with the practice's staff and providers to answer questions and discuss their experiences with implementing the improvement strategy. If a practice does not achieve its goal by the deadline, the quality coordinator creates a revised action plan based on findings from the follow-up discussions.

Identifies external resources to further support improvement

After establishing an action plan, the quality coordinators consider which external resources could further support the practice in achieving its quality goals and improving beneficiary care. For example, SSACO includes several small, independent practices that do not provide immunizations on-site due to the cost and safety requirements for storing vaccines. However, this impacts their scores on immunization quality measures. To address this and help more beneficiaries receive their immunizations, the quality coordinators enlisted a pharmacy chain to offer an on-site clinic with flu and pneumococcal vaccinations at the practice locations. "If patients can go back to their primary care office to get a preventive test or vaccination done, some of them are more inclined to do it that way," said Hamilton. In another example, the quality coordinators sought to improve care for beneficiaries with diabetes by connecting primary care practices that did not have a retinal camera with ophthalmology groups willing to conduct on-site screenings. SSACO noted that bringing in external providers to provide immunizations and conduct screenings at the primary care practice was a more effective strategy for improving performance than having the primary care practice refer its patients to off-site services, because many patients do not follow through with off-site referrals.

Improving documentation with templates

SSACO recognized that practices that needed to improve documentation would benefit from receiving chart templates. For example, SSACO built a template that practices could adapt to their EHR systems to capture all elements of an annual wellness visit (AWV). The template defines the elements of the visit and includes prompts to ensure that providers do not miss required items. SSACO has also disseminated templates for fall screening, depression screening, and transitional care management.

The quality coordinators identify the appropriate template for a given practice and customize it to reflect the needs of the providers and staff. A single template may fit everyone's workflow in a large practice with employed physicians, while a customized template may be required for each of the providers in a smaller independent practice. The quality coordinators may also work with practices to add EHR fields—for example, to capture the date when a service was delivered or a screening was performed.

Figure 3

Sample completed action plan

Silver State ACO
Accountable Care Organization

ACTION PLAN

PRACTICE: Example SSACO Practice   DATE: 1/1/2019
                                          DUE DATE: 3/1/2019

Practice Goal Statement	To implement changes within the practice in order to raise the Quality Measure score
Resources and Desired Outcomes	Improve Quality Measure Scores within 60 days

Task #	Complete Fall Risk Screenings on patients 65 years of age or older
Strategy to Implement	• Perform a Fall Risk Screening on every patient utilizing a CMS approved screening tool [Timed Get up and Go, Morse Fall Scale, etc.] or by documenting in the patients chart the question, 'Have you fallen in the past 12 months?' with patients response

Task #	Complete Depression Screenings on patients 12 years of age or older
Strategy to Implement	• Perform a Depression Screening on every patient utilizing a CMS approved screening tool [PHQ-9, PHQ-2, Becks etc.] • Document interpretation of screening with a score of 1 or more and if positive, document a follow up plan

Task #	Provide or document patients receipt of an Influenza Vaccination
Strategy to Implement	• Identify whether or not patients have received an Influenza Vaccination and document in EMR record with the month and year • For those who have not received an Influenza Vaccination, provide vaccination or refer to Pharmacy during flu season • Document any refusals/allergies relating to Influenza in patient chart

Task #	Document results of Colorectal Cancer Screenings on patients between the ages of 50-75

Strategy to Implement	• Identify when patients last Colorectal Cancer Screening was completed
	• Document results along with year completed and type of test done
	• If due for screening provide referral for Colonoscopy, Cologuard, or FOBT etc..
	• Screening Timeline:
	  - FOBT during calendar year 2018
	  - Flexible sigmoidoscopy and CT Colonography good for 5 years
	  - Colonoscopy good for 10 years
	  - FIT DNA good for 3 years

TIPS:
▪ Utilize attached Questionnaire [Provide and have patients complete while waiting in the lobby]
▪ Complete and implement Tobacco Policy
▪ Build Templates in EMR
▪ Flag patients charts utilizing the Monthly Gap in Care Report

_____   _____   _____
PRACTICE STAFF SIGNATURE   DATE   PRINT NAME

_____   _____   _____
COORDINATOR SIGNATURE   DATE   PRINT NAME

RESULTS

After operating its provider feedback strategy for four years, SSACO saw notable increases in some CMS Web Interface Measures (see Table 2). In particular, SSACO increased its falls screening measure score from 31.5 percent in 2015 to 92.1 percent in 2018 by providing practices with templates to capture screenings that were already taking place. In addition, SSACO noted substantial improvements in the completion rate of AWVs and transitional care management visits. SSACO concluded that the improvement was driven by a combination of the providers' desire to improve their quality measure performance and the quality coordinators' success in identifying low-effort changes to documentation processes as well as in connecting practices with external resources. These efforts were particularly important for practices that began with low quality results. In one practice, the quality coordinator brought in an external chronic care management company to address care gaps and supported practice staff with implementing an AWV template. Just one year after implementing these changes, the practice doubled its overall quality score.

LESSONS LEARNED

SSACO considered strategies to engage providers in quality improvement efforts, both to gain buy-in during initial conversations about quality data and to maintain interest over time when implementing improvement strategies. The quality coordinators found that providers had questions about the validity of scorecard data and the expected impact of the proposed action plan. The coordinators used regular, in-person meetings to review the data in detail, consider insight from patient charts, and point to documentation gaps related to CMS measures. In these meetings, the vast majority of providers sought to understand their data and identify strategies to improve quality for their patients. In very few instances, practices refused to make the changes outlined in their action plans. This led SSACO to exclude from the ACO participant list those practices that refused to make changes.

The quality coordinators learned to treat cardiology practices differently from primary care practices in setting quality improvement goals. For example, they encouraged cardiology practices to improve their scores on specialty-relevant measures such as blood pressure control for patients with hypertension. The quality coordinators placed less emphasis on getting cardiology groups to improve performance on primary care–focused measures such as mammograms or depression screenings. However, the quality coordinators did help the cardiology groups improve on some primary care–related screening measures by working with them to build in processes to reach out to their patients' primary care providers and obtain the results of screenings to enter into patients' medical records.

Many primary care practices struggled with improving performance on the colorectal cancer screening measure. To help with this challenge, SSACO's quality coordinators worked with practices to test a couple of approaches, hoping to find the one that worked best. One practice partnered with an external vendor to send fecal occult blood test kits to patients, while another practice mailed the kits to patients directly without the use of a vendor. SSACO's quality coordinators found that both approaches performed equally well, but the external vendor was a more economical option for the practices. Based on the results of this experiment, SSACO extended the external screening service to all of its practices.

Table 2

SSACO quality results, 2015 and 2018

Source	Measure	2015 score (%)	2018 score (%)
CMS	Overall Quality Score	87.5	90.2[a]
	Falls: Screening for Future Fall Risk (QI #318)	31.5	92.1
	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet (QI #204)	75.0	90.6
SSACO	Percentage of AWVs completed	8.6	26.0
	Transitional care management visits per 1,000	14.8	36.9

[a]This score is from 2017 because the 2018 Overall Quality Scores were not available prior to publication of this case study.
AWV = annual wellness visit; QI = Quality ID (CMS).

"We have two practices that joke, 'No, I'm going to be No. 1 this year.' And I love that because they strive to do well, and they're both high scoring."

—Rhonda Hamilton, Chief Operating Officer

Providers appeared to be particularly motivated to engage in quality improvement efforts when they considered the possibility of shared savings, which SSACO achieved in three out of four performance years in the MSSP. The quality coordinators saw that providers became particularly interested in making changes to improve quality results after realizing partway through the second performance year that SSACO was positioned to earn shared savings. As this program has evolved, many practices now strive to be among the highest-performing practices in the ACO. During the four years of the provider feedback program, providers have become more invested in quality improvement efforts: they now ask the quality coordinators more detailed questions about their data and their action plans.

NEXT STEPS

To continue improving its provider feedback strategy, SSACO is considering integrating its scorecards directly into the existing practice EHR systems. So far, the cost for this improvement has been prohibitive for the practices. SSACO is also looking into how to give providers more insight into Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data, which is only available at the ACO level and is not integrated into the current analytics system. Over time, SSACO will refine the list of measures included in the scorecards to reflect progress made on the current group of measures.