

## Maximizing Provider Engagement in Value Based Care

**PROBLEM:** Incomplete diagnosis, assessment, evaluation and documentation of patients' medical problems results in significant financial losses for organizations under value-based care contracts and represents suboptimal care of patients.

**GOAL:** The goal of this project is to use implementation science principles to help providers identify all significant medical conditions during clinical encounters and facilitate clinical documentation (aka billing and coding). We will determine where barriers currently exist in this process and propose evidence-informed interventions to improve outcomes. The result will be enhanced chronic disease management and financial stability for the organization.

**INTRODUCTION:** In value-based care models, reimbursement rates for patients vary according to patients' health status. In a process known as Risk Adjustment, health status is quantified based on patient age, sex, disability status, and certain medical problems. Problems included are those known to create complex medical needs and higher cost of care. The process of Risk Adjustment was developed to ensure providers who care for patients with complex medical needs are appropriately compensated for the additional effort required. Using a patient's health status to determine the likely cost of care helps set more accurate reimbursement rates in global payment contracts.

To manage the process, CMS categories medical problems into categories known as Hierarchical Condition Categories (HCC). Each condition in a HCC is assigned a numerical risk score known as a Risk Adjustment Factor (RAF). When calculating the cost of care for a patient, each medical problems corresponding RAF is added up to create a risk profile to determine reimbursement rates for care. The exact formula and risk categories used by private insurance companies are not known, but is understood to be similar to the CMS process, which are publically available. Payers rely on the diagnostic codes used in visit billing/coding to determine each patient's risk profile. The more medical conditions a patient has, the higher the risk score, and the higher the payment we receive. Of note, Medicare patient diagnoses are included in the risk score only when they have been evaluated during a face-to-face visit (telemedicine qualifies) in the previous calendar year. Medicare patient's risk-profile re-sets to condition-free January 1 of each year.

Ideally patients with chronic medical problems are seen at least once a year to have these conditions assessed and managed. However, ensuring this gets done can be tricky. For example, patients do not independently make appointments each year; access can create barriers; visit time can be insufficient to address a myriad of medical problems; and finally even when all else goes well, billing and coding for each diagnosis may not be accurate. Getting the pieces to fall into place, results in higher quality care and ensures that we are paid appropriately to care for patients with complex needs. The amount paid for a patient with no documented illness in contrast to those with a few medical problems correctly documented is significant. This differential is critical to the financial wellbeing of the organization.

Atrius Health currently employs multiple strategies to ensure patients are seen, their chronic conditions are easily identifiable, and provider documentation is complete in a process we call RAF-Capture. Despite these efforts there is still a gap. We approached the challenge of improving RAF-Capture by focusing on provider engagement as it is critical driver of success.<sup>1</sup> To be clear, we specifically will not be addressing issues related to patient outreach, patient access or visit length. Nor are we questioning the validity of the risk adjustment process in setting rates.

We structured our work using the Implementation Science framework i-PARIHS (Integrated-Promoting Action on Research Implementation in Health Services). Implementation Science provides a rigorous way of evaluating a problem to determine evidence-based interventions, processes, and outcome measures.<sup>2</sup> i-PARIHS structure for successful implementation of an innovation:<sup>3,4</sup>

Successful Implementation = Facilitation (Innovation + Recipients + Context)
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Factors contributing to successful implementation include qualities of the innovation itself (“what” is being implemented), characteristics of the recipients of the given innovation (“who” are the intended users, e.g., PCP), context (“where” implementation is occurring, e.g., primary care practices within Atrius) and facilitation (“how” implementation is being enacted). Successful implementation of our interventions will be measured by improvement of RAF-Capture rates, the percent of chronic diagnosis present on the problem list in a patient’s chart that have been addressed and coded in a given year.

**METHODS:** We started with an inventory of current efforts at RAF-Capture at Atrius (*attachment A*). With a focus on provider engagement, we considered characteristics of providers at Atrius in relation to their rates of RAF-capture including years in practice, FTE and panel size. We then conducted 11 semi-structured interviews with a carefully chosen set of providers using the attached guide (*attachment B*). We chose providers with both high and low rates of RAF-Capture, low and higher number of years with Atrius, and from a variety of clinic sites. The interviews gathered data on providers’ understanding of the role of risk adjustment and the process of RAF-capture. We queried them on perceived barriers and facilitators to both addressing patient’s chronic medical conditions and to producing appropriate billing and coding. Interviews lasted approximately 30 minutes and were done by ZOOM. We found that our data became saturated at interview 9, and continued to 11 interviews to verify data saturation. To reach data saturation, 11 interviews is considered sufficient in the limited domains we are addressing.<sup>5,6</sup> Data saturation is reached when the ability to obtain new information is no longer feasible.

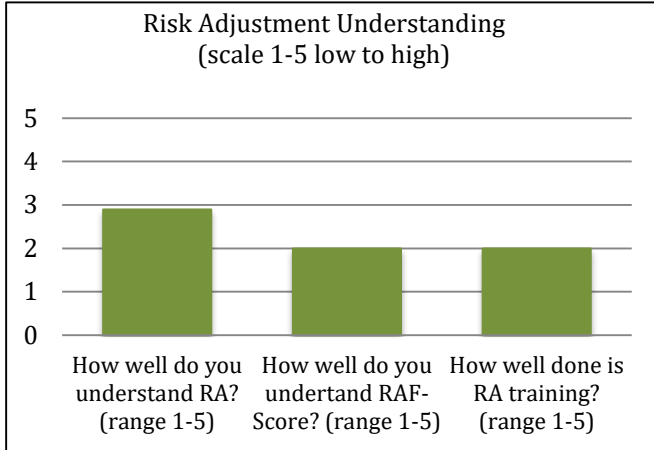
**RESULTS:** We found no correlation between years of practice at Atrius, FTE or panel size [RAF-potential is a proxy for panel size] on the rates of RAF-Capture (*attachment C*). We found providers who have been at Atrius for years who had excellent rates and those with poor rates, and similar findings for FTE and panel size. These data indicate that clinicians do not necessarily improve over time, nor do small panel size or fewer hours at work necessarily lead to improved RAF-Capture.

From our stakeholder interviews, we identified the following barriers (*Table 1 and 2*). We

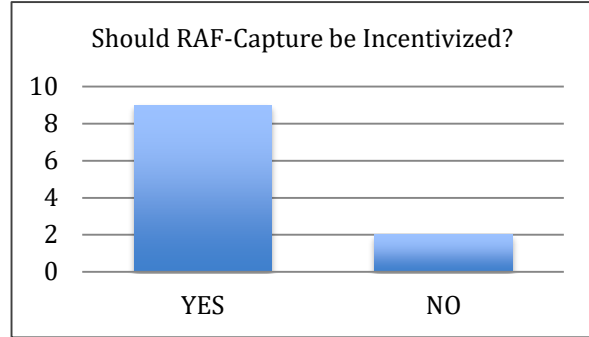
1. Low understanding of purpose of risk adjustment  
*“Until you explained this to me today, I did not understand the financial impact, I don’t think lots of us know this”*
2. Insufficient understanding of process of RAF-capture  
*“I’m not always sure what to do with the HCC form, or how to document”*
3. Low rates of RAF-capture feedback  
*“I hear about HCC from time to time in staff meetings – it feels like a scolding – and I don’t get consistent feedback on how I am doing.”*
4. Desire for incentive for RAF-capture rates  
*“A cash bonus would be nice for doing the extra work”*

Of interest we found that the 3 PCPs with best understanding of RAF capture hold administrative roles at the organization.

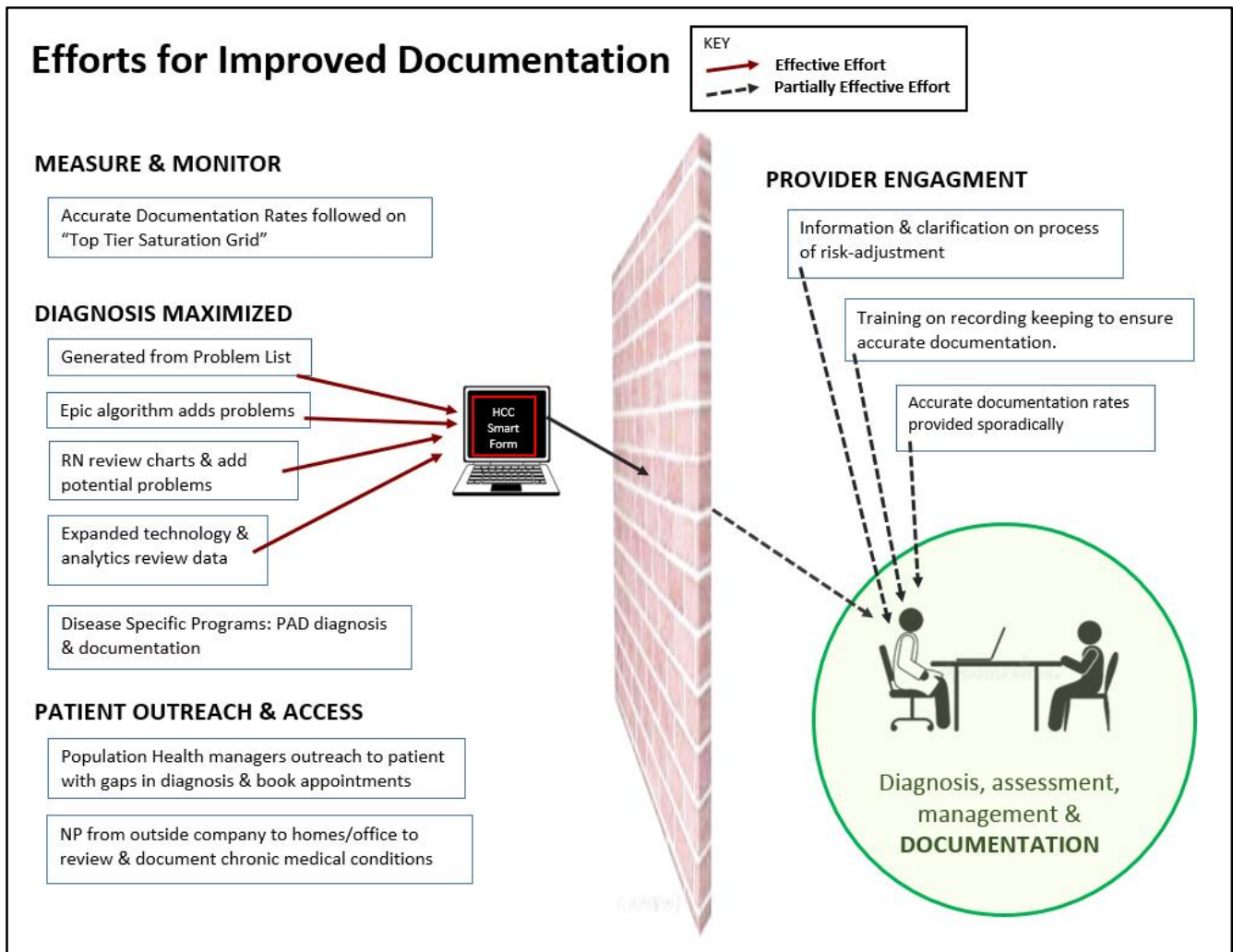
**TABLE 1 Result from Providers Interviews**



**TABLE 2 Results from Provider Interviews**



**CONCEPT MAP:** Combining data from interviews and current efforts at Atrius to improve RAF-Capture, we created a concept map. The image illustrates that multiple efforts are at play behind the scenes, while current efforts at provider engagement are not completely effective.



**IMPLEMENTATION SCIENCE FRAMEWORK:** To determine interventions that would have a high likelihood of success, we then organized these data according to the i-PARIHS framework, with the constructs of recipients, context, facilitation and successful implementation (*table 3*).

**TABLE 3: i-PARIHS Constructs**

i-PARIHS Construct	Key Findings
Approaches of evidence-based innovations	<ul style="list-style-type: none"> <li>• Educate on the “why” to align with values</li> <li>• Promote Relative Advantage – intervention that adds quality of care and financial stability</li> <li>• High Usability – interventions must be easy to use and tailored to users</li> <li>• Audit and Feedback – feedback must be timely, clear and accurate</li> <li>• Alter incentives – provide direct compensation for extra work</li> </ul>
Recipients PROVIDERS	<p>Values/Motivation:</p> <ul style="list-style-type: none"> <li>• Motivated to provide high quality care</li> <li>• As currently understood RAF-Capture does not align with values</li> <li>• No direct link to compensation</li> <li>• No correlation of years at Atrius, panel size or FTE with RAF-Capture Rates</li> </ul> <p>Resources:</p> <ul style="list-style-type: none"> <li>• EMR pop-up reminders (HCC SmartForm) provides RAF gap information but not well integrated nor understood by all</li> <li>• Sometimes limited access for patient</li> <li>• Limited time during visits</li> <li>• Multiple competing priorities</li> </ul>
Context	<p>INTERNAL</p> <ul style="list-style-type: none"> <li>• Will need time carved out for training and education thus Leadership support required</li> <li>• Multiple behind the scenes interventions ongoing that help provide chronic disease information to providers during visit (HCC SmartForm), patient appointments/access, and feedback to providers</li> <li>• Some sites have more RAF capture potential than others and may require increased focus</li> <li>• Turnover of staff creates gaps in knowledge and access – special attention to educating/training new staff</li> <li>• Structures (Epic) in place to facilitate process (HCC SmartForm) but not flexible enough and does not work well without problem based charting.</li> </ul> <p>EXTERNAL: Pandemic putting pressure on entire health care system</p>
Facilitations	<ul style="list-style-type: none"> <li>• Providing time and resources for education and training</li> <li>• Improved audit/feedback both in time and content</li> <li>• Incentives for improved rates</li> </ul>
Successful Implementation	<ul style="list-style-type: none"> <li>• Will be measured by change of rate of RAF-Capture and amount of increased revenue</li> <li>• Will be measured by survey of physician understanding of RA and RAF-capture</li> </ul> <p><i>Improvement in health outcomes achieved by increase in assessment of chronic health conditions is beyond the scope of this project.</i></p>

Combining the i-PARIHS categories with current efforts, we clarify interventions that would best suit the recipients in their context to determine the specific innovations needed to be successful. The innovations chosen were derived from expert recommendations for implementing change<sup>7</sup> and from examples in the literature.<sup>8,9</sup> This is a key features of Implementation Science – the innovations are not guesses, but rather chosen deliberately.

**Table 4 Innovation Formation**

ACTIVE EFFORTS RAF Capture*	Providers (Recipients)		Context		Facilitators	INNOVATIONS
	Description	Values/motivators	Resources	Internal		
RAF-Capture training embedded in in Billing/Coding training	As currently understood RAF Capture does not align with values	Limited access, limited time, multiple competing priorities	Requires leadership support.	COVID has stressed entire system	<b>Knowledge –</b> Providing time and resources for education	Clarify process and purpose of risk-adjustment via targeted education
HCC SmartForm pop-up in Epic	Motivated to provide high quality care but don't equate with RAF-Capture	EMR Epic universally used	Lack proficiency  Low rates of Problem based charting			<b>Know-How -</b> Providing time and resources for training
Rates provided intermittently	Respond well to comparative numbers and goal setting	Limited exposure to rates	Challenging to pull numbers  Messaging unclear		<b>Feedback –</b> increased interval & clarity	Provide regular audit and feedback on performance
No provider incentive	Respond well to financial incentives		Difficult to structure in		<b>Rewards -</b> Incentivize directly to providers	Create financial incentives

\* RAF-Capture describes the combined process of efforts of identification & outreach, chronic disease identification, and provider's assessment and documentation

**CONCLUSION:** To address the suboptimal rates of RAF-capture, the following innovations that address Provider Engagement should be considered:

1. Targeted education providers on basics of risk adjustment concepts, outlining the purpose, financial impact and quality enhancement potential.
2. Targeted training on best-practices for RAF-Capture including:
  - Harnessing reminders in EMR (HCC SmartForm) – workflows that facilitate use, specifics on use and/or how avoid.
  - Consolidate multiple RAF-Capture related Tip-Sheets to provide backup from training.
3. Provide regular audit and feedback with succinct messaging on performance.
4. Create financial incentives for providers. Of note, most Optum employed PCPs have RAF-capture included in their compensation models and it is considered industry best practice to compensate providers in alignment with how the organization is reimbursed in a value-based care model. The way it is incorporated varies across organizations.

**DISCUSSION:** Multiple strategies including monitoring rates of RAF-Capture, efforts to ensure patients are seen, measures to ensure chronic diseases are easily identifiable to providers during charting, and pop-up reminders for clinicians are currently employed. Nonetheless, not enough effort is made to ensure providers understand the basics of risk-adjustment, importance of accurate record keeping or how to harness resources ease the process. Providers are also not being given sufficient feedback or incentivized to improve. Addressing these issues by Investing in provider engagement will improved financial stability and increase quality of care.

Strengths of this project include its leveraging of implementation science and data gathered directly from stakeholders. There are several limitations worth noting: We chose the i-PARIHS framework, however, there are numerous other frameworks that may have value when examining implementation. We focused on provider engagement in the process of RAF-Capture and there remain multiple constraints beyond providers control at play in improving RAF-Capture including patient access, visit length, and other competing demands that were not addressed

**Attachments:**

- A. Current Efforts of RAF Capture
- B. Interview Questions
- C. Characteristics of physicians

**NEXT STEPS:**

1. Work with Risk Adjustment Team to develop specific Interventions and choose which ones to use. Consider the following:
  - a. Flesh out specific targeted education & training to fit clinician's schedules and needs. Consider PEER to PEER training when possible; consider identifying and training champions. Review what is available in Optum library catalog
  - b. Consolidate "Tip-Sheets" on RAF capture on share-space to provide backup documentation
  - c. Consider using a Learning Content Management System to manage and track the process and plan for ongoing training at regular intervals and with new staff
  - d. Consider stronger promotion of Problem Based Charting in Epic
  - e. Determine feedback mechanisms, messaging and timing
2. Work with Leadership team to consider creating incentives.
3. Pilot interventions at 2 strategically chosen sites to determine feasibility and validity. Compare rates of RAF-Capture to historical and comparative sites. Refine process as needed including education, feedback and incentive.
4. Expand to further clinic sites.

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