Establishing Clinical Quality Leads for Value-Based Care in Preventive Medicine

A Viewpoint on ACO Strategy

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Amanda Waid, MHA

Introduction

Communication and education of value-based care programs are vital for successful contract performance and increased quality of care for beneficiaries. Across all states, medical practices have experienced significant staffing changes and turnover due to the COVID-19 pandemic and healthcare burnout. Regardless of internal staffing changes, the demand for health services persists, and physicians and accountable care organizations (ACOs) must adapt. Affected the most in the value-based care space are primary care physicians and their patient populations seeking preventive services and management of chronic conditions.

Organizations like Imperium Health have recognized the market changes and acknowledged the staffing challenges many clinicians have continued to face since the pandemic. Similar to the healthcare economy, health management must evolve to survive the post-pandemic health space and continue to support clinicians on their mission to improve the quality of care, decrease the fragmentation of health services, and reduce the overall cost burden of health services. Imperium Health has worked diligently with participating clinicians to establish a Clinical Quality Lead as the primary contact for value-based care programs for the participating clinic and internal education.

Approach

As of calendar year 2023, time has become one of the most precious commodities for clinicians participating in the Medicare Shared Savings Program (MSSP), REACH, and other Medicare Advantage value-based care programs. However, education and communication of contract performance and outcomes are ongoing throughout the performance year. Imperium Health addresses continued education and communication by establishing early in the year a clinical quality lead within each participating practice to be the subject matter expert for value-based care. Clinical quality leads can be subject matter experts from various internal departments, including nursing, registration, practice management, or revenue cycle management (billing).

The most important aspects of selecting a clinical quality lead include time to assess program performance on a monthly cadence. Even if the monthly touchpoint is virtual, frequent communication and program review can lead to faster implementation of processes and fulfillment of clinical quality measures. The second aspect of establishing a clinical quality lead is the familiarity of internal processes. The ideal clinical quality lead is familiar with internal operations and the electronic health record (EHR) documentation process. Understanding interior health delivery design is pertinent to making any alterations in clinical function to capture preventive services pertaining to quality-of-life calculations in value-based care performance. While most clinicians may choose a staff member at the beginning of the health delivery cycle, registration, or nursing staff, members at the end of the cycle, such as billing personnel, maybe just as familiar with internal processes and experience more time for value-based program review. Overall, the quality clinic lead should have the time invested into the

practice to efficiently educate and apply the clinical changes necessary to improve the quality of care and reduce the financial burden for payers by improving care coordination.

Key Findings

In the first quarter of the performance year 2022, Imperium Health re-established clinical quality leads per participating clinic to address any changes to staff during the COVID-19 pandemic. The established clinic leads began attending routine ACO meetings monthly, and a 90% meeting cadence has been upheld through 2023. Regular communications with ACO participants resulted in a more precise understanding of program goals and requirements and more efficient process implementations for documentation capture across all departments. According to ACO operation directors, establishing the quality clinical lead in the practice setting has allowed for more subject matter training throughout the performance year and more in-depth education around a multitude of topics within the MSSP and other value-based programs. One example of how training has begun to advance internally for ACOs is transitioning from basic HCC-coding guidelines for risk adjustment application to specific diagnostic group-level education and required documentation for the services rendered. With changes to the annual physician fee schedule, continuing education is vital for healthcare delivery operations and success in value-based care programs.

Educational ACO provisions for the clinical quality lead are then delegated internally in the manner best suited for the medical practice, its staff, and its specific patient population. Monthly touchpoints with Imperium Health enable the clinical quality lead to increase program performance contributions within their department initially before beginning phased education in other areas of clinical operations. Depending on the subject, the clinical quality lead may start at the front of the process to educate registration staff on new processes or data capture needed to improve quality care services. The following phases provide the same alterations to processes by staff and providers. Having fixed calendar meeting occurrences allows the clinical quality lead to execute ACO education and communication within a goal of 30 days or more between touchpoints. Current clinical quality leads report being able to include at least one ACO-related process as part of their daily routine and integrating some responsibility seamlessly into already established processes. Quality leads are now being considered the clinic's internal subject matter experts and liaisons to the ACO for clinical quality care.

Implications

The ACOs that choose to implement the clinical quality lead design can face many implications of this process. Imperium Health has attested to improved education, which is justified by increased requests for more detailed training and access to education materials. The increased communication requests for training have reflected the maintenance and improvement of quality performance for Imperium Health ACOs. The improved involvement

and performance of ACOs allow the governing Board to decide on taking more advanced risk tracks in Medicare value-based programs in future performance years.

Other implications of establishing a clinical quality lead remain the challenge of availability. Some leads explain the growing list of responsibilities due to remaining staffing shortages. Imperium Health pivots to minimizing the monthly priority process with these participants. Additionally, significant variations in experience and ACO knowledge make the clinical lead onboarding process vary in length and content depending on the staff member. More success is seen with staff members with an extensive work history within a clinic or a management-level staff member with the leadership power to assign responsibilities and change clinical processes. Ultimately, many practices claim that the clinical quality lead position is now a full-time position, including daily documentation, patient outreach, process actions, and constant oversight and management of performance thresholds.

Conclusion

Participant involvement with the improved performance of an ACO starts with internal representation and assignment of program oversight. Education can be disseminated using external and internal ACO resources; however, the most successful implementations are derived from clinic leads with existing knowledge of daily operations. Imperium Health is most notable for its practice transformation efforts provided to ACO participants in a variety of value-based care performance contracts. However, the priority is always the beneficiary and their needs, so timely communication and minimal operational changes to medical practice often derive from successful partnerships between ACO management and internal staff.