# Patient Re-engagement Quality Improvement Toolkit

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# BCBSVT Primary
# Patient Re-engagement Quality Improvement Toolkit

## Introduction to the Patient Re-engagement Quality Improvement Toolkit

Blue Cross Blue Shield of Vermont (BCBSVT) has identified that a sizeable proportion of individuals with applicable plans have not been to see their primary care provider (or had any interaction with a healthcare provider) between May 1, 2018 and April 30, 2019. Additionally, a considerable proportion of this population falls into the age range where higher incidence of health issues and chronic disease burden occurs.

Blue Cross and Blue Shield of Vermont (BCBSVT), OneCare Vermont and the Vermont Blueprint for Health (the Blueprint) have come together to support practices as they work to re-engage with patients and improve access to primary care. The aim of addressing this population is to find ways to ensure preventive screening and care, and manage ongoing health concerns.

In order to support practices in their effort to re-engage with patients, the BCBSVT Primary Program includes $100 per member per year (PMPY) payments to the participating provider's TIN that delivers a qualifying primary care service to patients who had no BCBSVT claims between May 1, 2018 and April 30, 2019. This toolkit has been created to support your practice re-engage patients and unlock the $100 per member per year (PMPY) payments.

## Overview of BCBSVT Primary Program:

The BCBSVT Primary Program is a new program, distinct from both the BCBSVT Commercial and UVMMC Self-Funded Programs. Below is a table of key differentiators:

| | BCBSVT Commercial | UVMMC Self-Funded | BCBSVT Primary |
|---|---|---|---|
| **Shared Savings** | ✓ | ✓ | ✗ |
| **Downside Risk** | ✓ | ✗ | ✗ |
| **Care Coordination** | ✓ | ✓ | ✗ |
| **Quality Measures** | ✓ | ✓ | ✗ |
| **OneCare Supplemental Payments** | ✓ | ✓ | ✗ |
| **Primary Care Engagement Payments** | ✗ | ✗ | ✓ |

### Attribution

Attributed individuals in Blue Cross Blue Shield of Vermont's (BCBSVT) Primary Payer Population includes individuals that are:

- Commercially insured by a BCBSVT large group product
- Commercially insured by a BCBSVT association health plan product, or
- Insured by a self-funded employer plan that has a third party administrator or other management agreement with BCBSVT

Program available to organizations that provide primary care services participating in the 2019 BCBSVT Commercial program.

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### Program payments

Participating providers will continue to receive fee-for-service payments and will continue to submit claims to BCBSVT the same way, with no change to claims processing.

Participating providers are eligible to receive payments for primary care engagement:

- $3.25 per member per month (PMPM) to the attributing provider's TIN for patients that are actively engaged
- $100 per member per year (PMPY) to the participating provider's TIN that delivers a qualifying primary care service to patients that are NOT actively engaged

Active engagement in primary care is defined as having a qualifying primary care service between May 1, 2018 and April 30, 2019. Payments will be begin after OneCare receives data on attributed lives from BCBSVT. Payments are retroactive to May 2019.

## Patient Re-engagement Quality Improvement Process

The following section is designed to support your practice in a quality improvement initiative to re-engage patients. The process asks your team to:

- Identify root cause(s) for patients reduced engagement
- Based on identified root cause(s), select strategies to test engagement
- Test and understand the impact of the strategies

### Identifying Root Causes

The Five Whys and the Cause and Effect Diagram are two tools that can be used either together or separately to identify possible causes behind an issue. By identifying causes, a team will know where to focus their quality improvement energies and also where to measure their intervention's effectiveness.

1. The Five Whys is a simple tool to structure a conversation to identify the root cause of an issue. When a team asks "why" five times, usually the problem identified after the first and the fifth "whys" are very different and likely require different interventions.

   To complete the Five Whys, follow these steps (paraphrased from the Institute for Healthcare Quality Improvement (IHI) "5 Whys" article):

   1. Define the problem as an event by asking "What happened?"
   2. Define the problem as a pattern by asking "What has been happening?"
   3. Uncover the reasons why this is happening by asking first "Why is this happening?"
      a. Follow up the answer with the question "Why is that?"
      b. Repeat this process three more times to reach the fifth "why".
   4. Once the fifth "why" has been uncovered, ask the group "What can we do to change what is happening?"

   Your team can stop here or go on to complete in a Cause and Effect Diagram.

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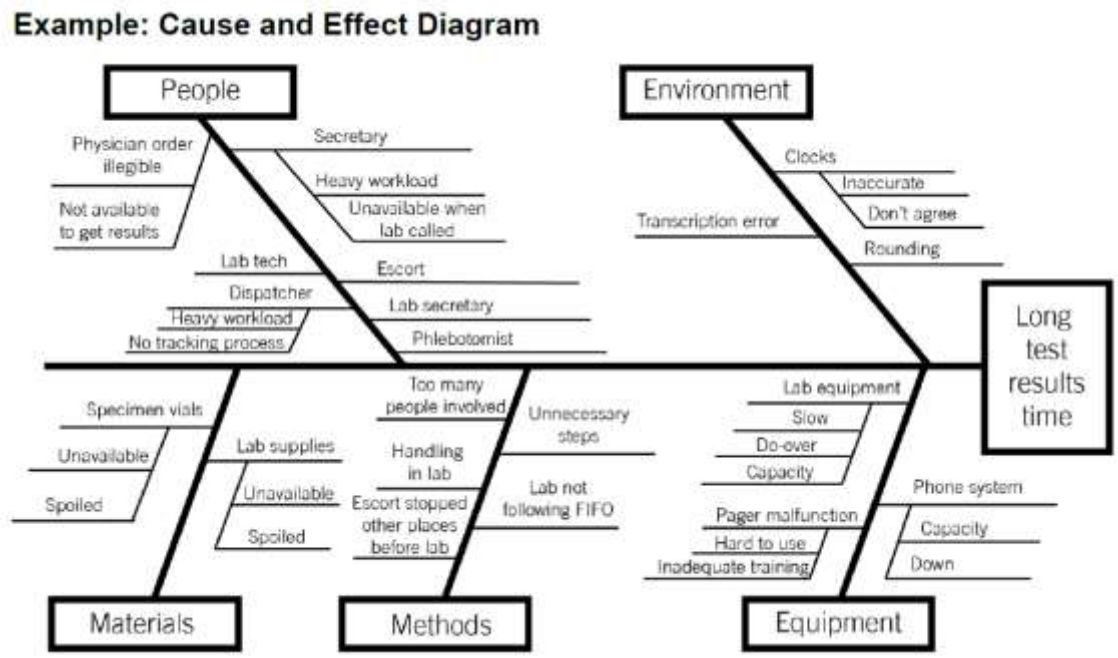
2. The Cause and Effect Diagram (also known as the Ishikawa or fishbone diagram) is one tool to explore multiple reasons (causes) for an identified issue (effect).

   Below are the instructions on how to complete a Cause and Effect Diagram (taken from the IHI QI Essentials Toolkit):

   1. Write the effect you wish to influence in a box on the right-hand side of the page.
      a. See the example on the following page.
   2. Draw a horizontal line across the page to the left, starting at the box you just drew.
   3. Decide on five or six categories of causes for the effect. The standard categories in a classic cause and effect diagram are Materials, Methods, Equipment, Environment, and People.
   4. Draw diagonal lines above and below the horizontal line to create "fishbones," and label each line at the end with one of the categories you have chosen. Draw a box around each label.
   5. For each category, generate a list of the causes that contribute to the effect. List the causes by drawing "branch bones." As necessary, draw additional branch bones from the causes to show sub-causes




## Key Strategies

Depending on what your team identifies as the root cause for reduced patient engagement, one or more of the following key strategies may be appropriate for your team to test in your QI project.

1. Panel Management - When staff call or send letters to patients who do not have an upcoming appointment or have not been seen at the clinic recently, this is called out-reach panel management. Clinical staff can also alert patients about care gaps when they are in the clinic receiving care for an issue not related to the care gap in a process known as in-reach panel management.

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The American Medical Association (AMA) has an online course on panel management, including the "Six STEPS to implement panel management:

1. Develop a registry.
2. Use a health maintenance template.
3. Adopt clinical practice guidelines.
4. Select and train staff to serve as panel managers.
5. Identify care gaps.
6. Close care gaps through in-reach and out-reach.

Additionally, your practice will have access to a patient list through the OneCare Secure Portal of your BCBSVT Primary attributed patients who do not have a primary care claim in the last twelve months.

2. Improving Scheduling Processes – If your organization identified provider access and scheduling as a root cause, improving the scheduling process or processes may be a strategy your team would want to test. Right-sizing panels, open access scheduling and group visits are just a few of the ways scheduling can be modified to allow for greater access.

   Continuity and right-sizing panels – Please review this linked IHI article to learn more about how committing to a system that supports each physician seeing his or her own patients and right-sizing patient panels can improve access to PCPs without increasing workload.

   Open access – Please review this linked AHRQ article to learn more about open access. "Open access—also known as advanced access and same-day scheduling—is a method of scheduling in which all patients can receive an appointment slot on the day they call, almost always with their personal physician."

   Group visits – Group visits for patients with chronic conditions "offer staff a new and more satisfying way to interact with patients that makes efficient use of resources, improves access and uses group process to help motivate behavior change and improve outcomes." The Cooperative Health Care Clinic (CHCC) model was developed by Kaiser Colorado and a copy of their "Group Visit Start Kit" can be found here on IHI's website.

3. Integrating Telemedicine into the Practice – If the root cause identified by your team relates to patients not making it to appointments due to transportation issues, one possible solution is telemedicine. Telemedicine is often seen as an ambitious or complex undertaking. This article from Medical Economics addresses some of the common concerns and highlights many of the benefits to integrating telemedicine into a primary care setting.

4. Incentives for Appointments – Costs can be a significant barrier to patients and may be one of the root causes your team identified. With the $100 PMPY unlocked through the BCBSVT Primary program, your team may decide to offer incentives to patients. This Health Affairs article highlights "how small cash incentives can encourage primary care visits by low-income people with new health coverage". Additionally, the Annals of Family Medicine has an article that highlights how "offering incentives to patients for reaching health goals has the potential to foster a stronger partnership between doctors and patients and improve health outcomes".

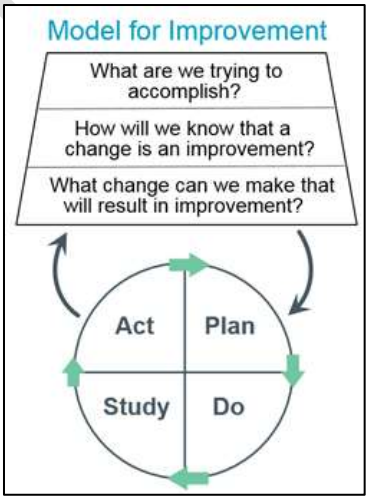
5. Patient Education – Perhaps the root cause your team identified relates to patients' reluctance to schedule an annual preventive due to cost concerns. You may have also identified adolescents have the lowest rate of annual visits, a possible cause being parents or the adolescents do not see a need for annual well-visits to the PCP and only visit when there is an acute illness or a need for a sports physical.

   Patient Education on Preventive Services – Blue Cross and Blue Shield of Vermont has a guide for its members on its website on what preventive services are covered at 100% with no patient cost share. BCBSVT also encourages its members to contact its customer service team by calling the number on the back of the member's BCBSVT ID card if they have any questions.

   Promoting Adolescent Well-Visits – The National Adolescent and Young Adult Health Information Center has recently released a collection of eye-catching materials and infographics to encourage parents and adolescents to make and keep annual well-visits.

## Measuring Progress

The Plan-Do-Study-Act (PDSA) cycle is a useful tool to track and assess your team's progress. Once your team has selected a strategy to test, it is important to implement a process to study the change you are testing.




IHI has an article that explains the PDSA cycle and provides steps to use it successfully:

- **Step 1: Plan** - Plan the test or observation, including a plan for collecting data.
  - State the objective of the test.
  - Make predictions about what will happen and why.
  - Develop a plan to test the change. (Who? What? When? Where? What data need to be collected?)
- **Step 2: Do** - Try out the test on a small scale.
  - Carry out the test.
  - Document problems and unexpected observations.
  - Begin analysis of the data.
- **Step 3: Study** - Set aside time to analyze the data and study the results.
  - Complete the analysis of the data.
  - Compare the data to your predictions.
  - Summarize and reflect on what was learned.
- **Step 4: Act** - Refine the change, based on what was learned from the test.
  - Determine what modifications should be made.
  - Prepare a plan for the next test.

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## Additional Resources

- Institute for Healthcare Improvement – Primary Care Access Strategies
  - http://www.ihi.org/topics/PrimaryCareAccess/Pages/default.aspx
- Primary Care Team Guide
  - http://www.improvingprimarycare.org/work/enhancing-access
- Center for Primary Care Innovation – Sample QI Strategies
  - https://www.massgeneral.org/stoecklecenter/assets/pdf/webcast_slides/improving_access_to_primary_care.pdf
- Measuring Access to Primary Care Appointments: A Review of Methods
  - https://www.ncbi.nlm.nih.gov/pmc/articles/PMC169167/