Privia Quality Network Written Operational Plans

The operational plans outlined in this document promote individualized care programs for improved outcomes for high-risk and multiple chronic condition patients. Depending on the operational state of the ACO, the plans outlined in this document may, or may not be, incorporated into day-to-day operations.

Clinical teams are encouraged to utilize the information in this document to guide operational tactics that support clinical management of Medicare beneficiaries.

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Introduction

Privia Quality Networks (PQNs) are committed to supporting our providers and suppliers to improve the overall quality of care while lowering costs for all Medicare beneficiaries. The PQNs have partnered with vendors, community partners or developed our own proprietary software to better manage healthcare services. The PQNs understand that each clinician, and their clinical team, are at different stages of their value based care journey. It is important to recognize that not all of these options may be appropriate for all PQN participants; however, the PQN's goal is to reduce variation in services and care delivery across the spectrum. Over time, as a provider or supplier's value based care capabilities mature, a well rounded, all encompassing care delivery system is the goal.

Electronic Health Records

CEHRT Certified Electronic Medical Records Systems

As expectations from CMS and CMMI continue to progress, it is imperative, our ACO participants are aligned with CEHRT certified EHRs. CMS provides a comprehensive list of EMR vendors that meet this designation. Certifications will be verified through the Certified Health IT List maintained by the ONC Health IT Certification program. The ACOs operational leaders will collaborate with participants on the requirements and benefits of utilizing a CEHRT certified EHR. If participating entities elect to not utilize a CEHRT certified EHR, per the ACO participation agreement, the entity will be removed from ACO participation.

In addition to this requirement, the PQNs will be cognizant of the EHR's data abstraction capabilities. Being able to report on electronic Clinical Quality Measures (eCQM) will be a CMS requirement for PQN's performance. The PQN's Primary Quality Contact will be responsible for ensuring the ACO is aligned to report quality measures.

Beneficiary Identification and Individualized Care Plans

Patient Identification

The PQNs have a structured process to obtain and securely analyze Medicare data to create transparent, actionable reports for participants. Participating providers and suppliers are provided reports that identify attributed beneficiaries with data insights which includes, but is not limited to, patient specific chronic conditions, ER and IP utilization and quality measure gaps. The data available is robust and allows participating suppliers to make informed decisions on the best way to manage their patient population.

The below table outlines reports, the cadence of these reports and the intended purpose for each.

Report Name	Delivery Cadence	Purpose
Cost and Utilization Reports		
MSSP Performance Topline	Quarterly	High level ACO review of trended benchmark, attribution growth and current total cost of care. Mainly used at the board level.
MSSP Cost and Utilization	Quarterly	Create transparency in year over year total cost of care for participants and participating suppliers.
MSSP Summary Report	Quarterly	Summary of NPI level total cost of care that compares year over year 12 month periods.
Patient Clinical Management Reports		
Diabetes Management Report	Monthly	Focuses on patients with diabetes to identify beneficiaries that need to be engaged.
Chronic Kidney Disease Report	Daily	Identifies patients who have a recent eGFR that denotes kidney disease and whether or not the patient has had a microalbumin test.
Patient Roster Report	Monthly	Identify open care gaps and engage patients.

Diabetes Bundle Program

Diabetes is one of the most prevalent chronic conditions in the United States. The PQNs have completed an analysis of beneficiaries with diabetes total cost of care when four diabetes quality measures are completed vs not completed. It is apparent, based on the analyzed data, that patients who are engaged and adhere to completing quality measures have a lower total cost of care.

The Diabetes Bundle Program creates a mechanism for practicing clinicians to identify, and take action on, beneficiaries diagnosed with diabetes who are not compliant for the focused quality measures. The PQNs are able to review the performance of this population at the ACO, facility and individual clinician levels.

Collaborative Care Models

Mindoula's solutions for providers help clinician practices, health systems and hospitals treat patients with complex behavioral health, medical and social challenges, and help move providers from fee-for-service to value-based models of care.

Through strategic partnership, Mindoula has been integrated into the athena system for seamless management of patients referred for collaborative care management. Through this integration, participating clinicians are able to easily identify patients, engage in care and serve the patient population. The partnership allows our participating clinicians and Mindoula care managers to analyze patient clinical improvement through the services.

Amalgam

Amalgam empowers patients and clinicians to make the best healthcare decisions possible. The PQNs clinical members can utilize the technology of Amalgam directly in the EMR for clinical decision support and patient engagement.

Brilliant Care

BrilliantCare focuses on proactive hypertension and diabetes population health management using personalized nurse access, high-touch care coordination and advanced remote technology. Their products and services enhance the ability of healthcare practitioners to provide optimal and augmented care to their patients in today's dynamic, challenging healthcare environment while reducing the total cost-of-care.

Telehealth and Remote Patient Monitoring Services

Privia Virtual Clinic

The Privia Virtual Clinic improves patient access to high-value, after-hours services that keeps care coordinated between beneficiaries and their primary care clinician. By increasing accessibility, beneficiaries have an enhanced experience and improved health outcomes.

The Privia Virtual Clinic has dedicated virtual health medical directors that lead monthly peer reviews to ensure quality assurance. The clinical range for the Privia Virtual Clinic includes multiple states and specialities. The clinical team follows comprehensive virtual care guidelines to create consistency in healthcare delivery.

Care Advice Line

The goal of the Care Advice Line, which is available 24/7/365, is to reduce unnecessary visits to the emergency department, provide information for self-care and symptom management, to coordinate care across the healthcare delivery system and connect patients back to their PCP. Staffed by RN Care Managers, the Care Advice Line supports participating clinicians by creating an additional access point for care.

Other Monitoring Services

Participating entities can choose a 3rd party vendor that best meets their needs to drive quality, lost cost care.

Electronic Exchange of Health Information

Athena - CommonWell Health Alliance

Is a not-for-profit trade association devoted to the simple vision that health data should be available to individuals and caregivers regardless of where care occurs. Athena has established a bi-directional feed with Commonwell that allows participating clinicians to receive and send patient information to improve communication between providers.

Athena - Carequality

Bringing together a diverse group of representatives, Carequality, includes electronic health record vendors, record locator service providers and other types of existing networks from the private and government sectors, to determine technical and policy agreements to enable data to flow between and among networks, platforms and geographies.

Promoting Interoperability

Starting in Performance Year 2025, all ACO participating entities are required to report promoting interoperability. ACO operational leaders will educate and support participating ACO entities to understand the intricacies of Promoting Interoperability reporting.

Electronic Case Reporting

Any Privia Medical Group entity utilizing any instance of athena has been configured with AIMS and the CDC to share communicable disease data as required by the QPP. As additional instances of athena are added, the EMR functionality for case reporting will be activated.

For groups outside of the Privia Medical Groups, the ACO operational team will provide education on the importance of establishing an eCR connection with their respective state health department.

Health IT Tools

Admission, Discharge and Transfer Applications

To create transparency in beneficiary movement through healthcare systems, the PQNs have partnered with ADT vendors to help clinicians identify and take action. For athena users, a recommended Transitional Care Management workflow can be found via this link: Transitional Care Management Workflow Guide

For clinicians that are not utilizing athena, the ACO will provide, when available, Privia Engage for participating entities to easily identify and outreach beneficiaries transitioning through the healthcare ecosystem.

VIM

A leading middleware platform for healthcare, VIM's proprietary EHR integration infrastructure allows PQNs that have clinicians utilizing various EHRs to disseminate data, patient and clinical insights, to the point of

patient care. VIM allows PQN participating clinicians to improve quality, risk adjustment accuracy and pharmacy management in a streamlined manner. https://getvim.com/

Privia Engage

To identify and engage beneficiaries, the PQNs participants have access to a platform that integrates data health plans and EHRs into a single source for use. By merging the two data sources, our participants can easily identify and take action when beneficiaries are eligible and not scheduled for an annual wellness visit or transitioning through the acute and post-acute settings.

Long Term and Short Term Post Acute Partners

ACO participants will be supported, through data, to identify high quality, low cost post-acute providers in their respective markets. The ACO operational teams will, at the direction of the ACO board, work with identified partners to streamline care. Periodically, ACO leadership will review long term and post-acute care entities to ensure care is being provided that strives to lower cost and improve quality.