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Utilization and Choosing Wisely

Tom Evans, MD

TCPi 2018 Learning Community

Delivery System Reform Requires Focus

Provider Payment

Care Delivery

Information Distribution

TCPi: 5 Phases of Transformation

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Source: CMS TCPI PTN Information Webinar, November 20, 2014.

TCP*i* Goals

1. Support more than 140,000 clinicians in their practice transformation work
2. Improve health outcomes for millions of Medicare, Medicaid and CHIP beneficiaries and other patients
3. Reduce unnecessary hospitalizations for 5 million patients
4. Generate $1 to $4 billion in savings to the federal government and commercial payers
5. Sustain efficient care delivery by reducing unnecessary testing and procedures
6. Transition 75% of practices completing the program to participate in Alternative Payment Models
7. Build the evidence base on practice transformation so that effective solutions can be scaled

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How It Began……

- In 2010, Howard Brody, MD, published *Medicine's Ethical Responsibility for Health Care Reform – The Top Five List* in NEJM
  - Challenged specialty societies to identify five tests/treatments that were overused and provided no meaningful benefit to patients
  - Internal Medicine was the first to respond, followed shortly by FM and Pediatrics
- There are now more than 80 societies that comprise just over one million clinicians that are now part of *Choosing Wisely*
- Furthermore, 19 other countries have started their own *Choosing Wisely* campaign

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Scope of the Problem

- In 2017, a survey sponsored by the ABIM Foundation found:
  - **75%** of U.S. Physicians reported the frequency with which physicians order unnecessary tests is a “serious problem” for America’s healthcare system
  - **69%** reported physicians ordered these tests at least once weekly
- Over **$750B** annually spent in unnecessary care in U.S.
  - **$395B** estimated due to physician-driven waste
  - Unnecessary labs, imaging studies, and chasing incidental findings of uncertain clinical significance

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- ABIM survey found that physicians exposed to *Choosing Wisely* campaign were:
  - ***less*** likely to order unnecessary tests – **nearly 1/3 reduction, or 59% to 43%**
- Another study found that while overall awareness was only 40%, those who were aware were, “significantly more likely to report reducing the number of unnecessary tests or procedures in the last 12 months”

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Benefits of Choosing Wisely

- Evidence-based recommendations
- Avoids potentially unnecessary testing
  - Decreases likelihood of identifying findings of doubtful or no clinical significance
  - Avoids risk of complications of invasive procedures, medications
  - Avoids unnecessary (and sometimes prolonged) surveillance
- Reduces costs: physical, emotional and financial
- This is, quite simply, better medicine

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Some Examples of CW Recommendations

- Society of General Internal Medicine (5)
- American Academy of Family Physicians (15)
- American Academy of Pediatrics (10)

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Society of General Internal Medicine

- **DO NOT** recommend daily home glucose testing in Type II diabetics on oral medications
- **DO NOT** perform routine general physicals and lab testing in asymptomatic adults with no chronic medical conditions or health concerns
- **DO NOT** perform routine preoperative testing before low risk procedures
- **DO NOT** recommend cancer screening in patients with life expectancy less than 10 years

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American Academy of Family Physicians

- **DO NOT** prescribe antibiotics for mild to moderate sinus infections unless symptoms last for at least 7 days, or worsen after initial improvement
- **DO NOT** prescribe antibiotics for otitis media in children between ages 2-12 where observation is an option
- **DO NOT** require a pelvic exam or other exam in order to prescribe oral contraceptives
- **DO NOT** routinely screen for prostate cancer using PSA or DRE
- **DO NOT** screen adolescents for scoliosis

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American Academy of Pediatrics

- Neuroimaging is **unnecessary** in a child with a simple febrile seizure
- CT scans are **not** necessary in the immediate evaluation of minor head injuries (use PECARN criteria)
- Cough and cold medicines should **not** be prescribed or recommended for children under four years of age.
- Antibiotics should **not** be used for apparent viral respiratory illnesses (sinusitis, pharyngitis, bronchitis, bronchiolitis)

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The "Iowa Five"

- **DO NOT** image the spine in patients with nonspecific low back pain, **and** do not image the spine for low back pain within first 6 weeks unless "red flags" present
- **DO NOT** image the brain for uncomplicated headaches
- **DO NOT** image the brain in the evaluation of syncope if the neurologic exam is normal
- **Avoid** unnecessary use of head CT/MRI in the evaluation of minor head injuries
- **DO NOT** order sinus CT or indiscriminately order antibiotics for uncomplicated for uncomplicated rhinosinusitis

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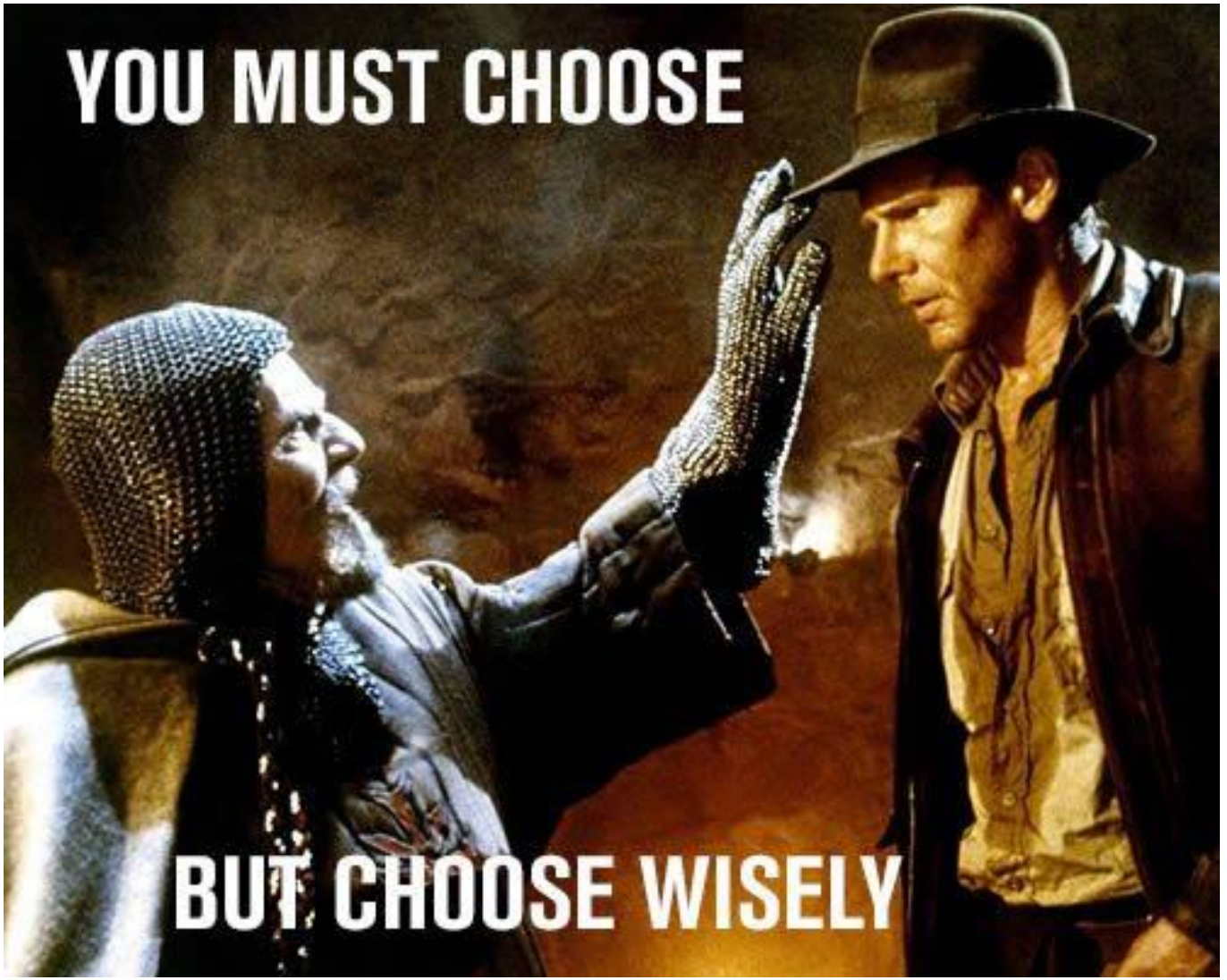
Compass PTN Utilization Measures

- **DO NOT** image the spine in patients with nonspecific low back pain, **and** do not image the spine for low back pain within first 6 weeks unless “red flags” present

- **DO NOT** prescribe antibiotics for mild to moderate sinus infections unless symptoms last for at least 7 days, or worsen after initial improvement

AND

- Employ techniques to avoid **ED Utilization**
(Cases avoided through the “Call me First” Campaign


YOU MUST CHOOSE
BUT CHOOSE WISELY

Practice Transformation Network

Iowa Healthcare Collaborative

Transforming Clinical Practice

The State of the Union

Tom Evans, MD

Compass PTN Learning Community

Summer 2018

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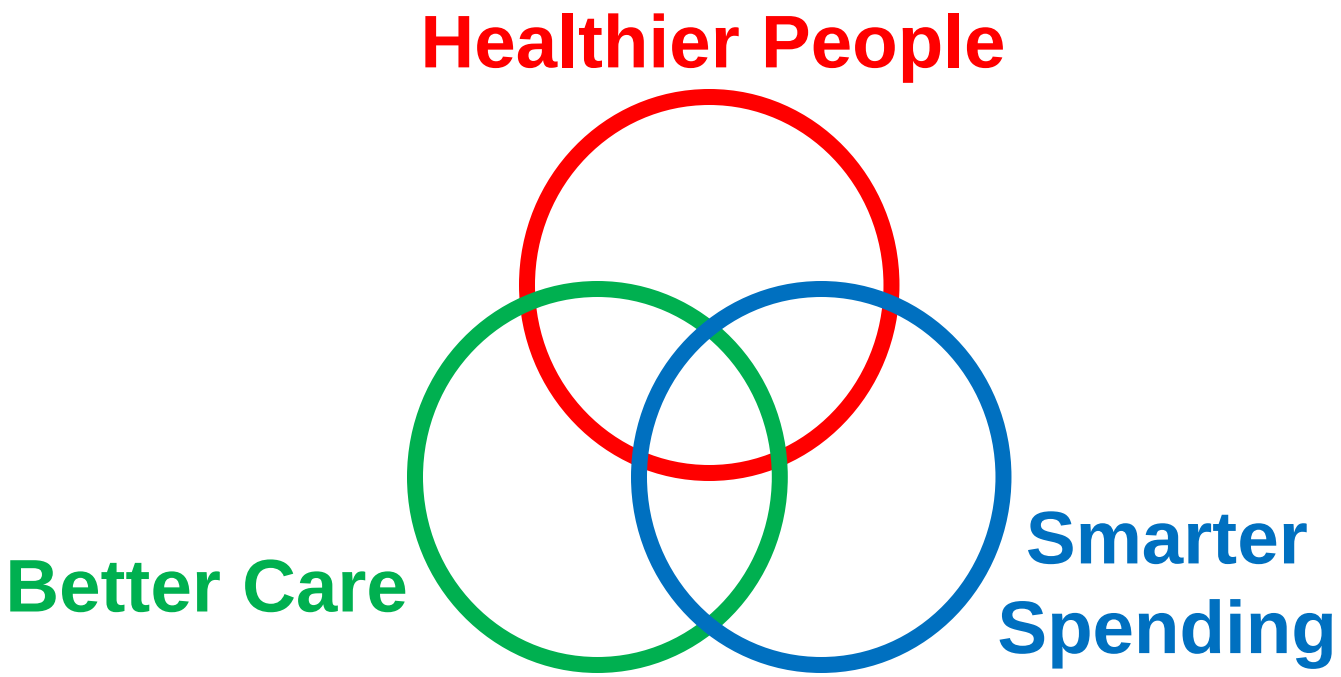
Objectives

- Discuss TCPi and next steps for clinicians and practices
- Recognize how these collaborative programs will affect quality improvement and facilitate whole-system transformation
- Explain the power of aims-based collaborative learning to achieve new levels of performance

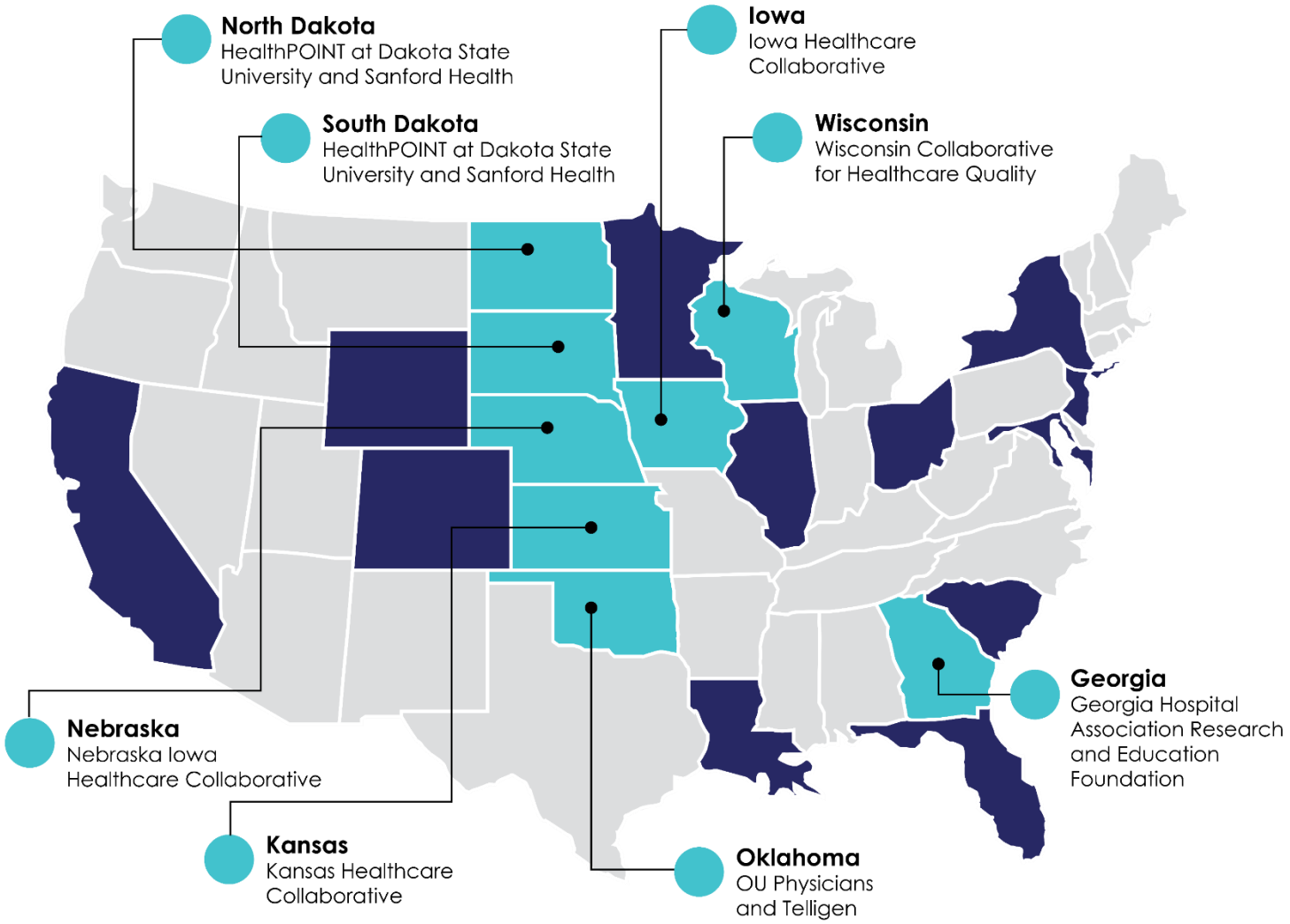
Delivery System Reform



The Triple Aim

National → State → Community

Practice Transformation Network


North Dakota
HealthPOINT at Dakota State University and Sanford Health
South Dakota
HealthPOINT at Dakota State University and Sanford Health
Iowa
Iowa Healthcare Collaborative
Wisconsin
Wisconsin Collaborative for Healthcare Quality
Georgia
Georgia Hospital Association Research and Education Foundation
Nebraska
Nebraska Iowa Healthcare Collaborative
Kansas
Kansas Healthcare Collaborative
Oklahoma
OU Physicians and Telligen

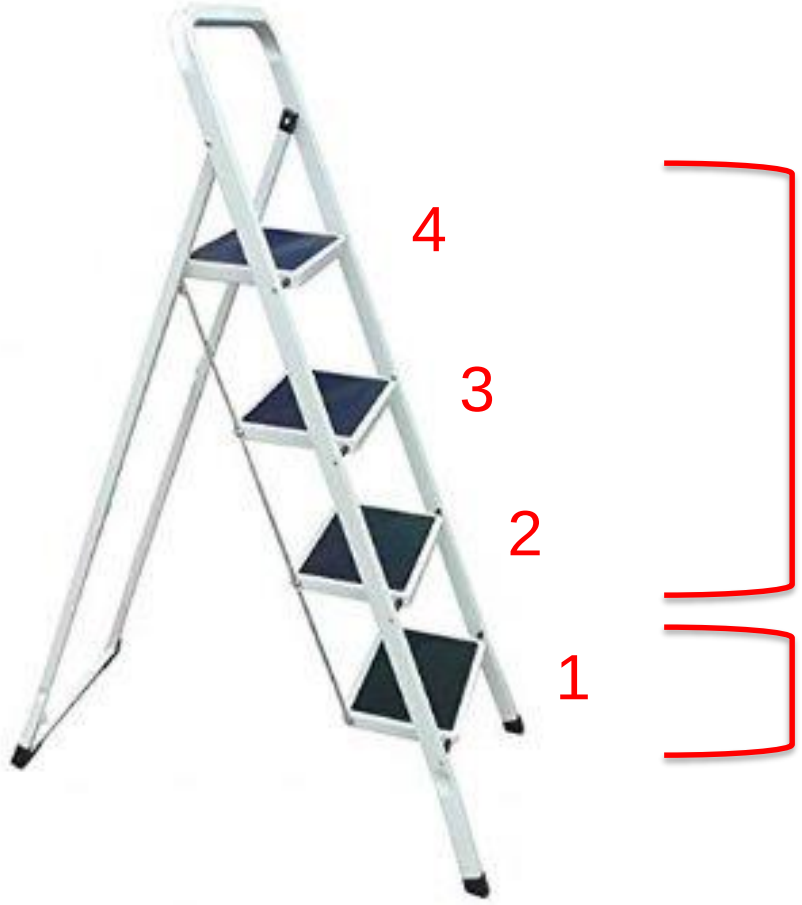
Delivery System Reform Requires Focus

Pay Providers

Deliver Care

Distribute Information

MACRA: QPP
Quality Payment Program



Alternative Payment Models (APM)

Merit-based Incentive Payment System (MIPS)

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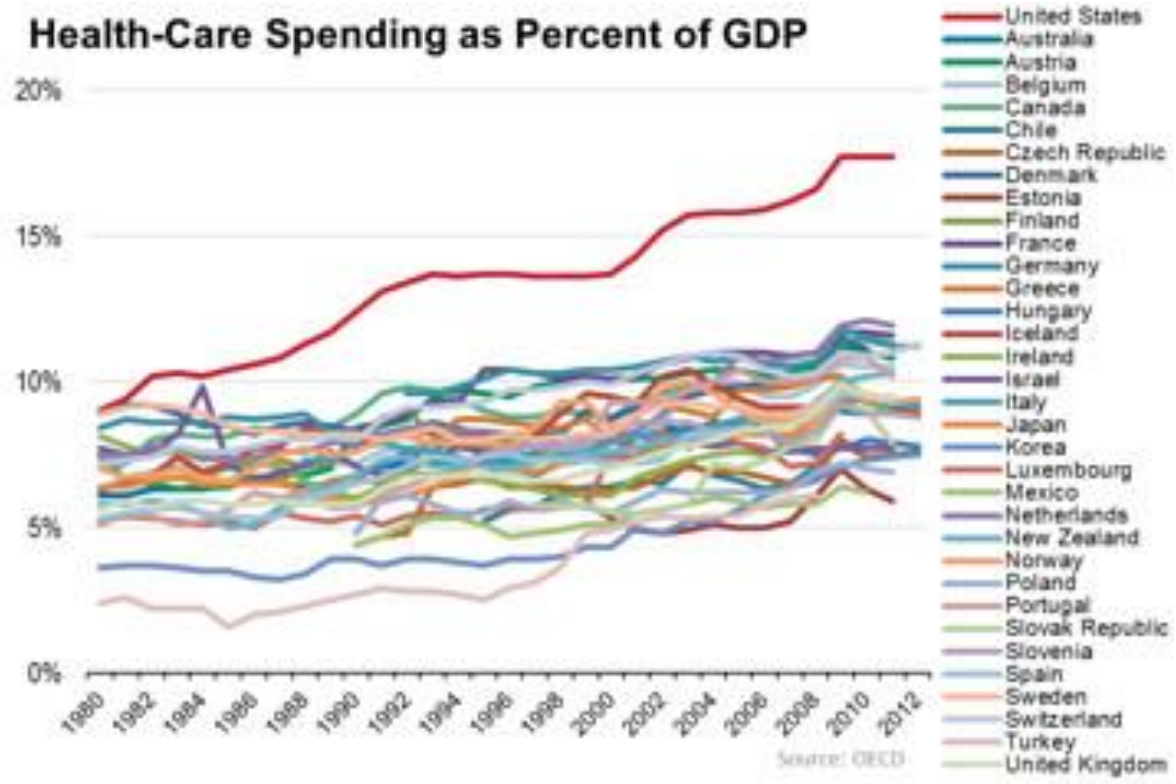
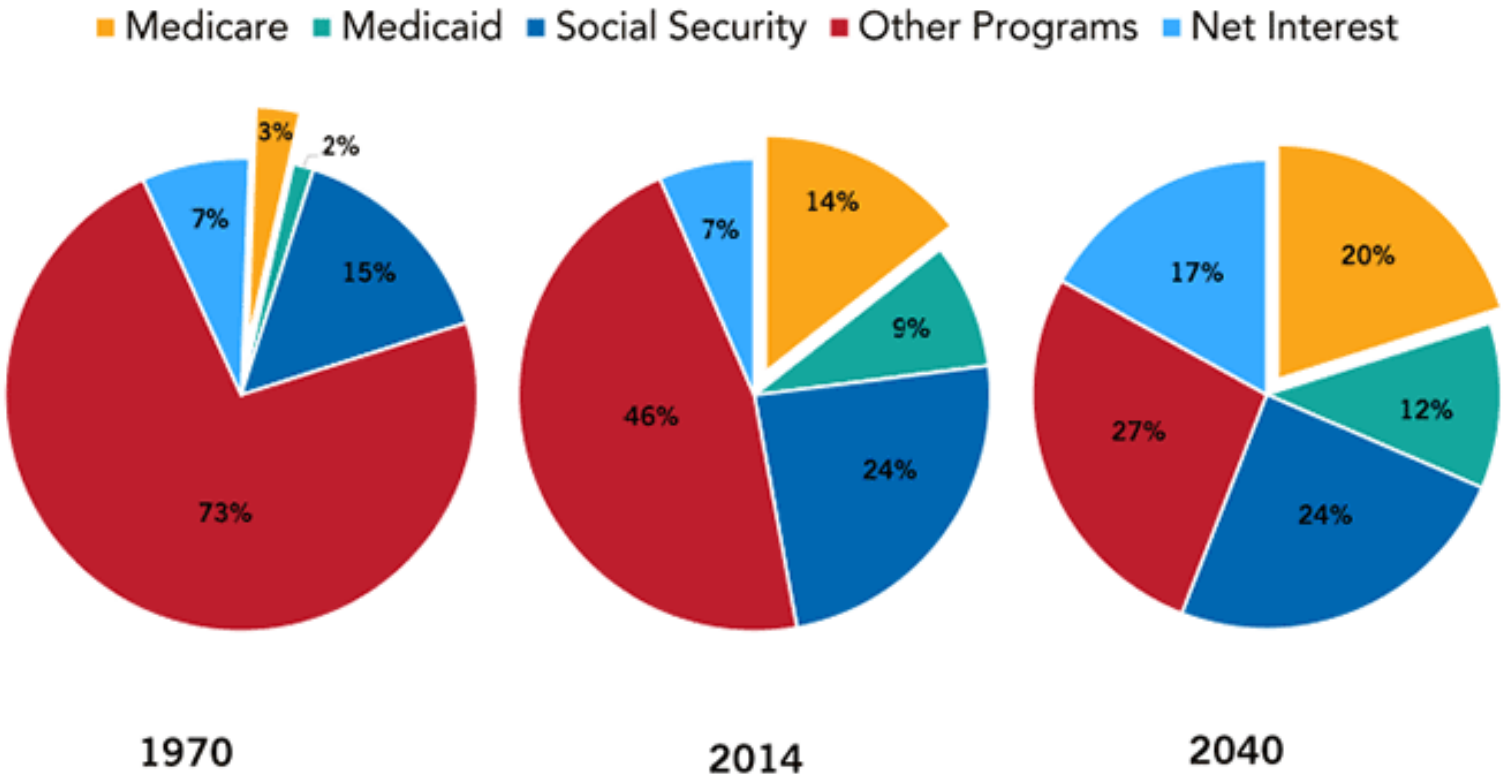
Health Care and GDP



PETER G. PETERSON FOUNDATION

Medicare spending is a growing share of the federal budget



SOURCE: Office of Management and Budget, *Budget of the United States Government*, Fiscal Year 2015, February 2015 and Congressional Budget Office, *The 2015 Long-Term Budget Outlook*, June 2015. Compiled by PGPF.

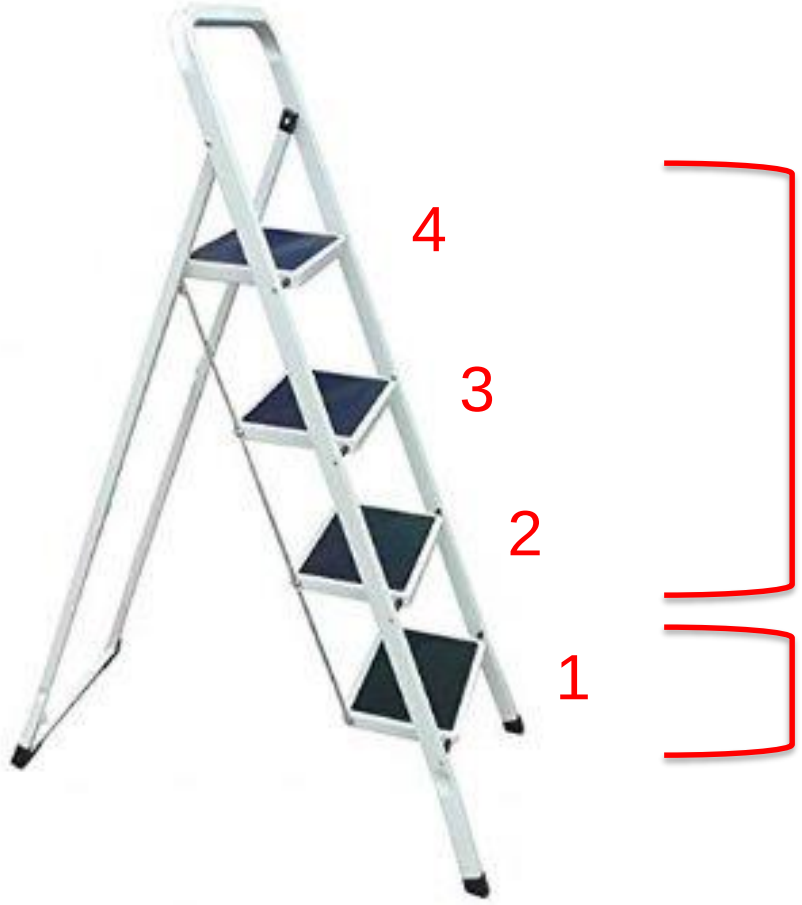
What an Opportunity!

Medicare Shared Savings Program (MSSP)

Department of Health and Human Services (HHS) ***Secretary Azar*** said in March that program "results have been lackluster," and Centers for Medicare & Medicaid Services (CMS) ***Administrator Seema Verma*** singled out one-sided risk ACOs for "increasing Medicare spending… encouraging consolidation in the market place, reducing competition and choice for our competition." *Verma concluded that "our system cannot afford to continue with models that are not producing results."*

Health Affairs Blog, July 22, 2018

MACRA: QPP
Quality Payment Program



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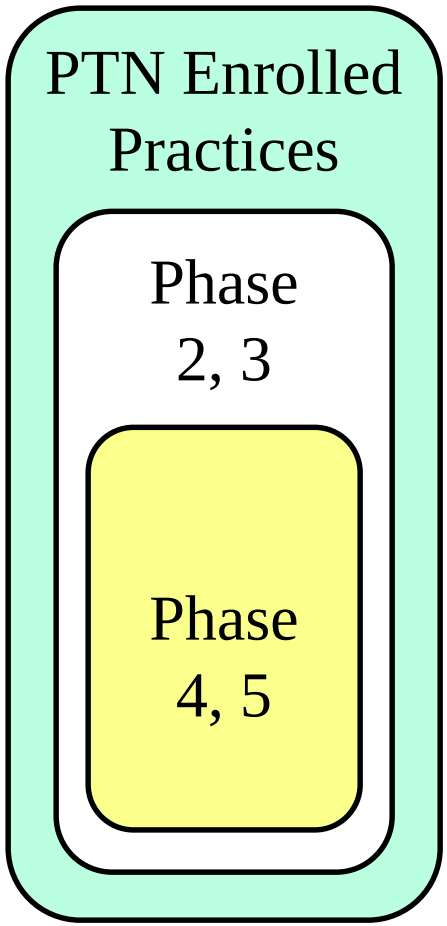
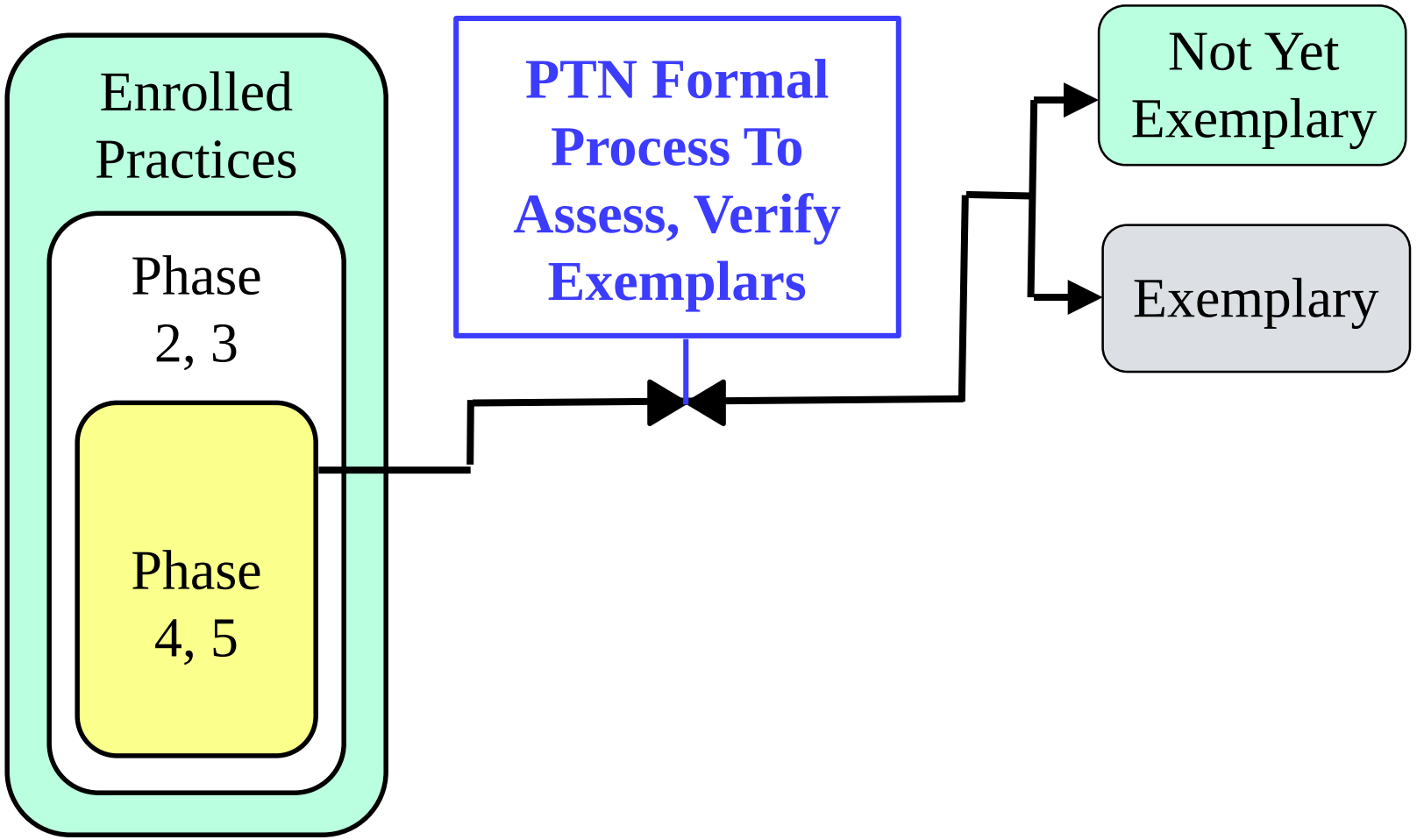
PTNs Determine Exemplars



Not Yet Exemplary

Exemplary

PTNs Determine Exemplars



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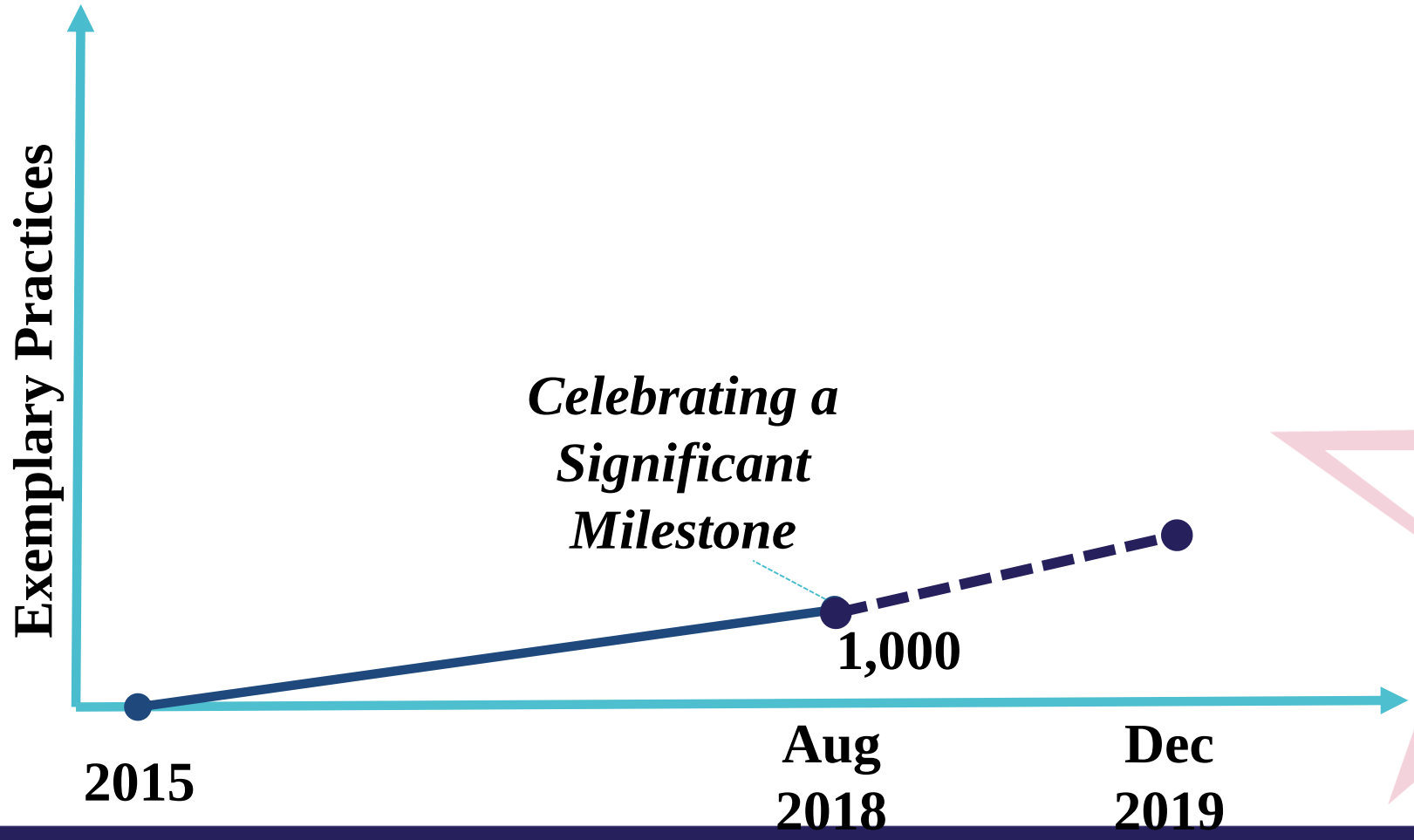
Identified Exemplary Practices



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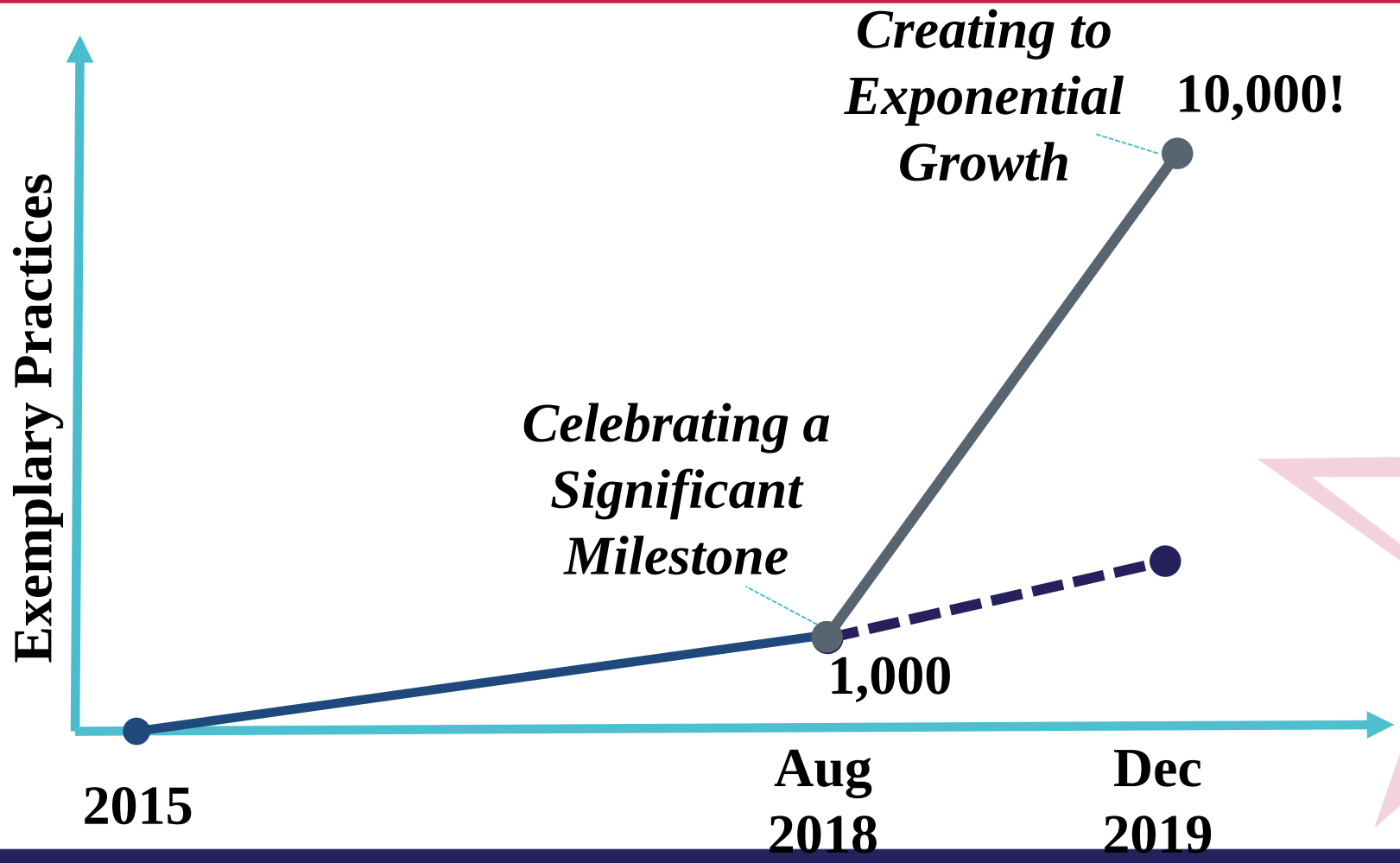
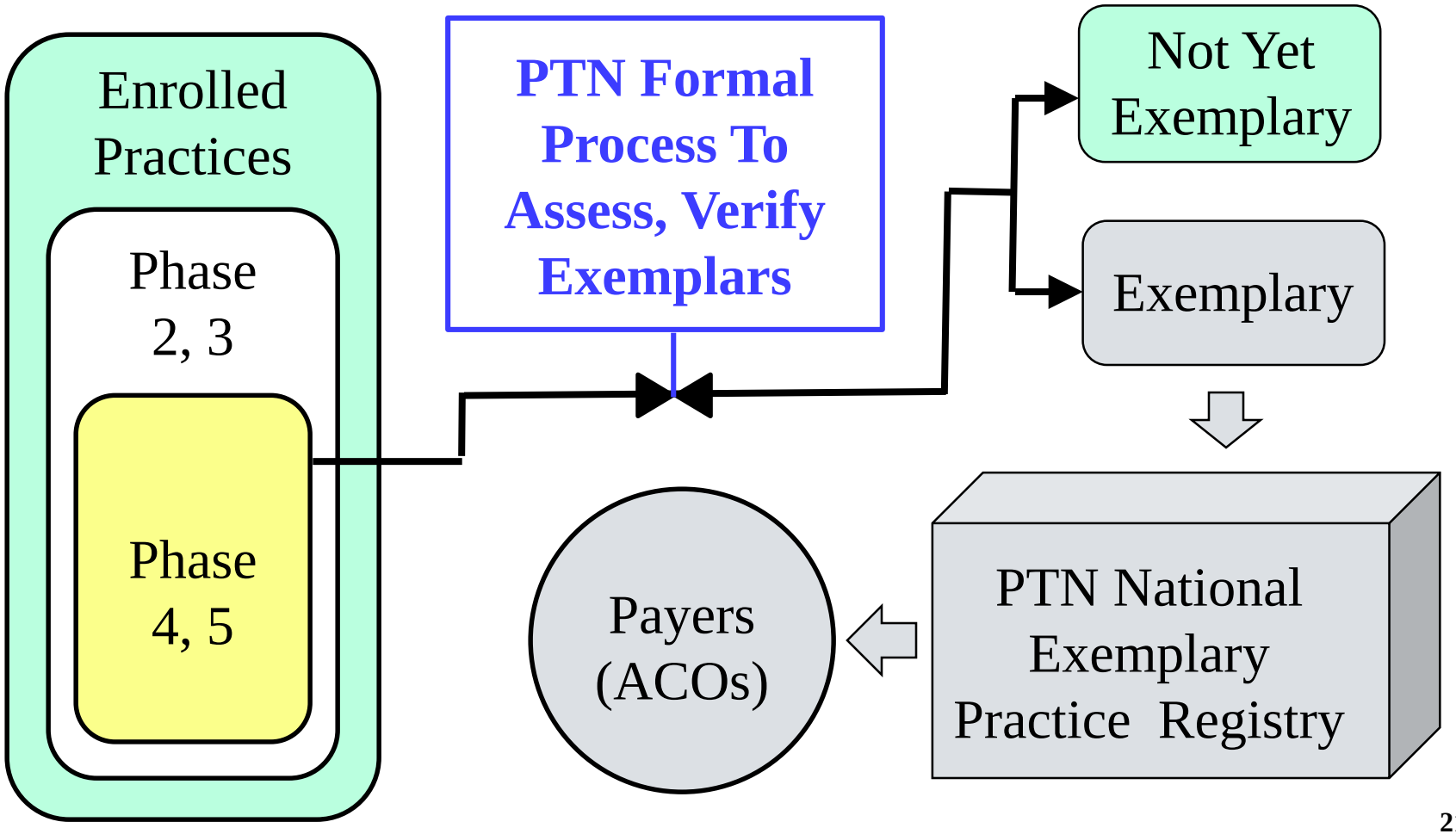
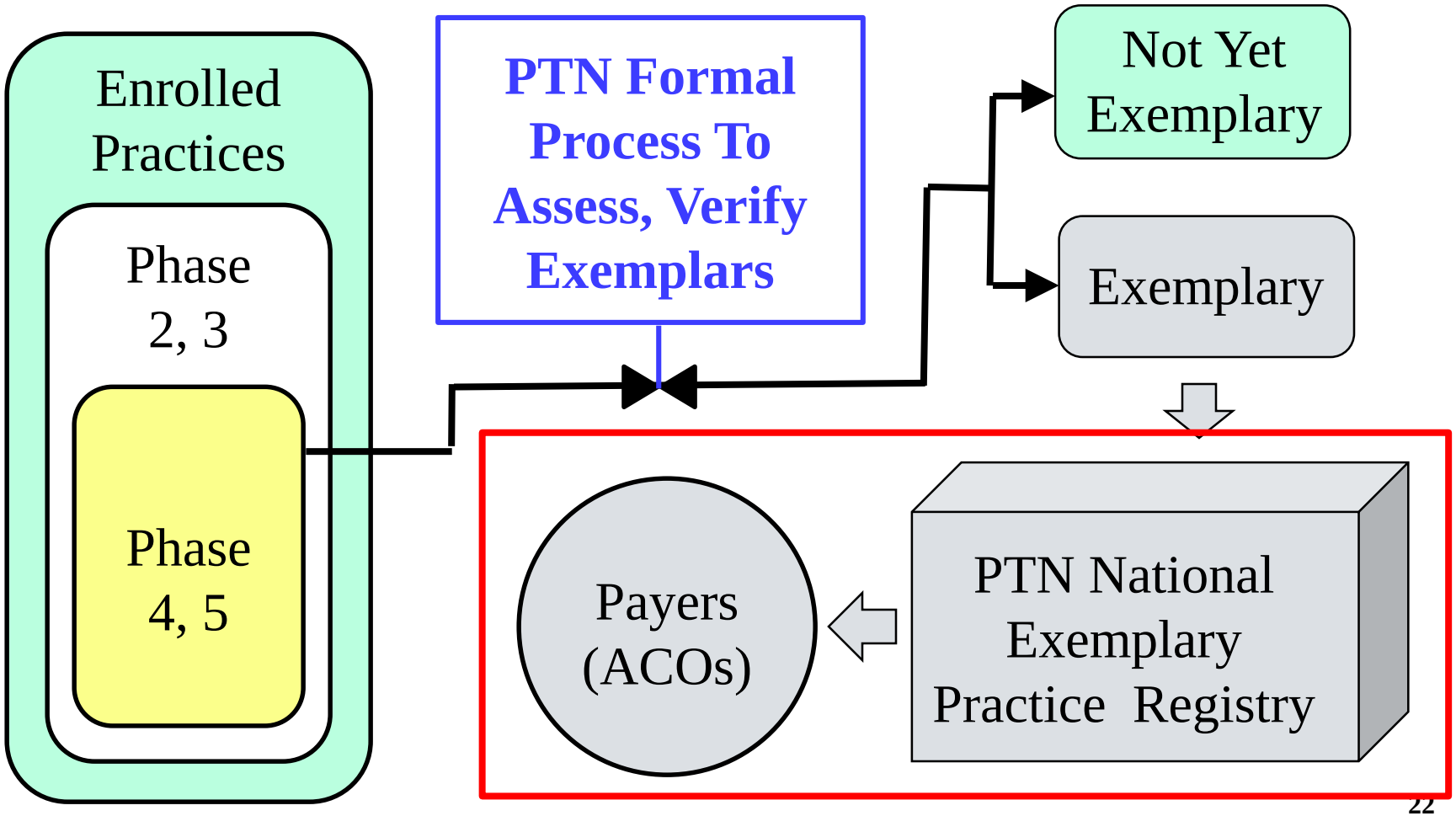
Achieving 10,000 Exemplary Practices



PTNs Determine Exemplars



PTNs Market Exemplars



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Compass PTN Definition of Exemplar Practices

- Phase Progression: Phase IV or V
- Provide a “Story Worth Emulating”
  - Practice can demonstrate (articulate and display) on at least 2 of the 4 TCPi Service Delivery Aims
    - (Outcomes, Utilization, Hospitalization, Tests and Procedures)
- Patient and Family Engagement (PFE)
  - Reporting on at least 3 of the 6 PFE measures

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A Story Worth Emulating

- Patient-centered Goal
  - What was the envisioned purpose of change
- Intervention
  - What did you do to change care
- Data
  - What measures? How did you use to inform process?
- Results
  - What happened?
- Patient-centered Impact
  - How was care improved from the patient's perspective?

On the Horizon…

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"On the Horizon" Take Home Points

- It's really going to happen. It can't not happen.
- From "more is better" to "better is more"
- You can run, but you can't hide. Data is the currency of improvement.
- Run hard on this last lap…maximize the resources available (i2i, ICE, QIAs, etc.)
- **Become an Exemplar**

Practice Transformation Network

THE CODING EDUCATOR

STEVEN ALLEN ADAMS, MCS, CPC, COC, CPC-I, CPMA, FCS, PCS, COA

Documentation Pearls for Surviving Payment for Performance

surviving value based medicine

Steve Adams, MCS, COC, CPC, CRC, CPMA, CPC-I, PCS, FCS, COA

email: steve.adams@inhealthps.com

web: thecodingeducator.com

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Payment for Performance

The goal of P4P is to improve quality and outcomes for patients. Reaching this goal is based on a set of changes in the way a patient receives care and the way providers quantify that care back to the plan via reporting, validating and coding of services.

Discussion Points

1. Quality Payment Program (QPP)
2. Accountable Care Organizations (ACO)
3. Clinically Integrated Network (CIN)
4. Bundled Payment Models (BPM)
5. Risk Adjustment Models (HCC and RAF)

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QPP

Quality Payment Program (QPP)

CMS rewards high value, high quality Medicare clinicians with payment increases - while at the same time reducing payments to those clinicians who aren’t meeting performance standards.

Merit-Based Incentive Payment System (MIPS)

MIPS **combines** parts of the Physician Quality Reporting System (**PQRS**), the Value Modifier (**VM** or Value-based Payment Modifier), and the Medicare Electronic Health Record (EHR) incentive program into one single program:

1. Quality
2. Cost
3. Promoting Interoperability
4. Advancing Care Information

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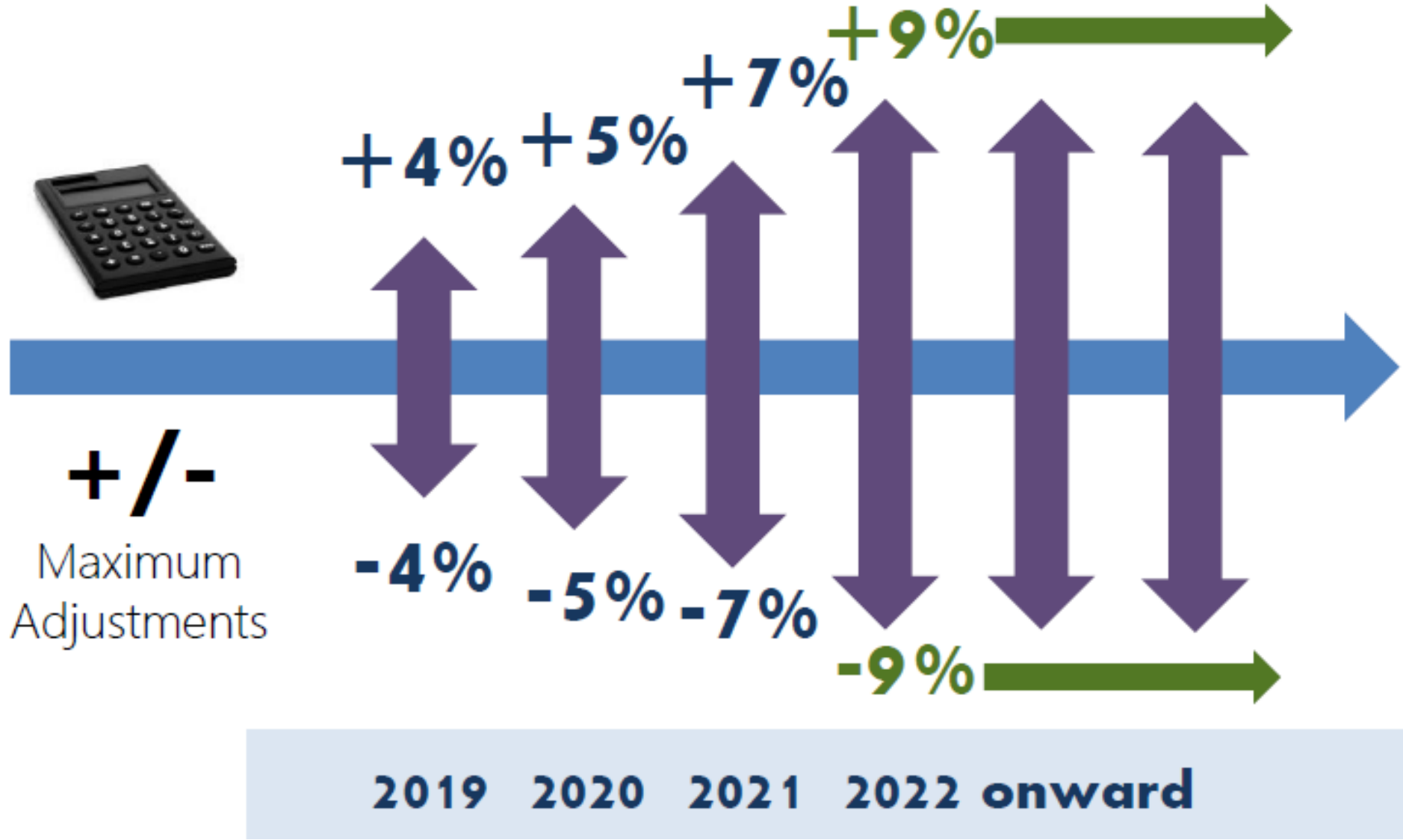
+4%
+5%
+7%
+9%
+/-
Maximum Adjustments
-4%
-5%
-7%
-9%
2019
2020
2021
2022 onward

Clinicians have two tracks to choose from in the Quality Payment Program based on their practice size, specialty, location, or patient population:

1. Merit-based Incentive Payment System (MIPS) or
2. Advanced Alternative Payment Models

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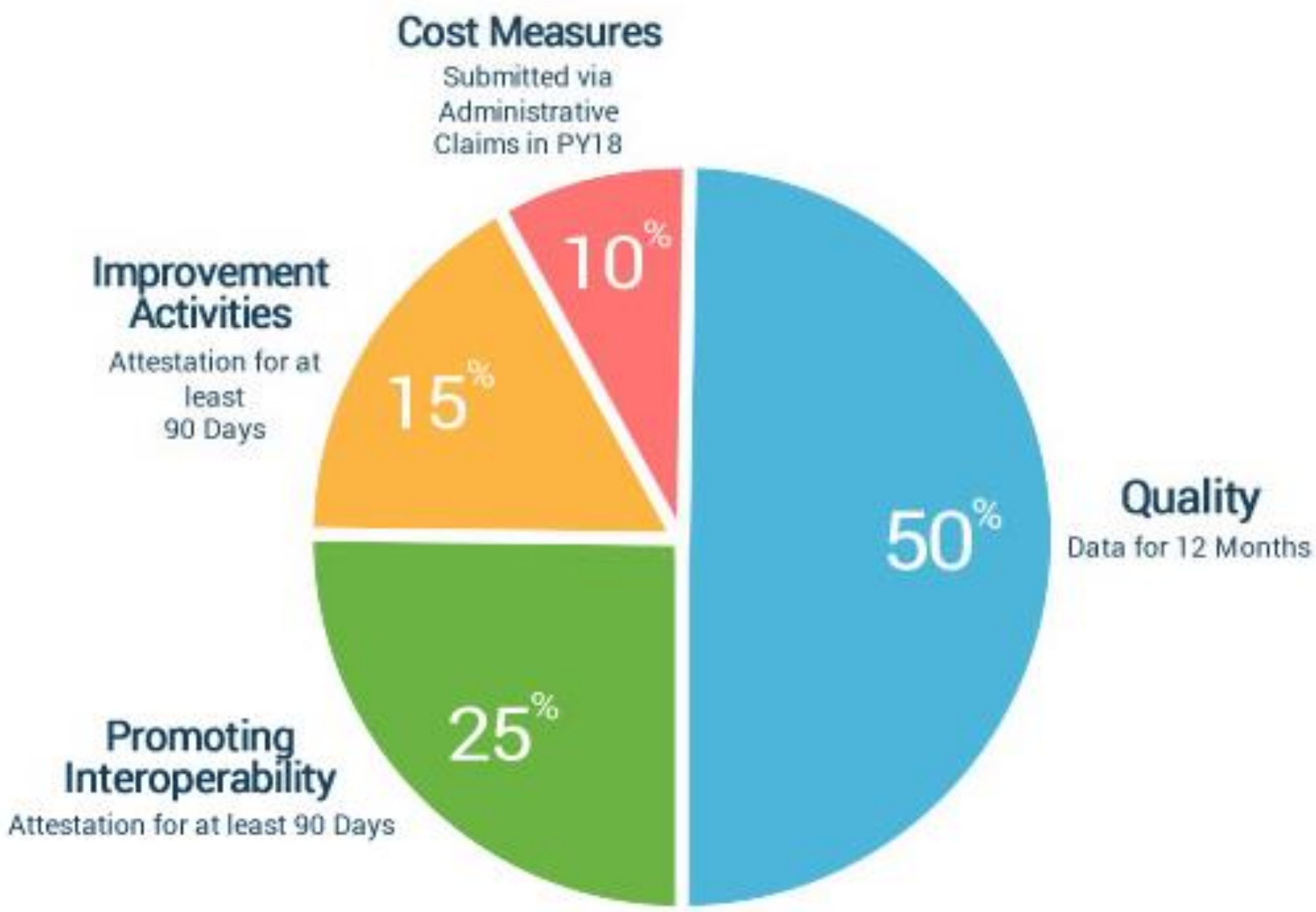
Cost Measures
Submitted via Administrative Claims in PY18
10%
Improvement Activities
Attestation for at least 90 Days
15%
50%
Quality
Data for 12 Months
25%
Promoting Interoperability
Attestation for at least 90 Days

Quality

2018 MIPS Quality

Patient Name: _____ **DOS:** _____

Do this on every Red White and Blue Medicare Patient

 # 1 DESCRIPTION: Hemoglobin A1c Management (only if the patient has type 1 or 2 DM)

Numerator Options (Pick One):

[ ] Most recent hemoglobin A1c (HbA1c) level less than 7.0% **(3044F)**

OR

[ ] Most recent hemoglobin A1c (HbA1c) level between 7.0 to 9.0% **(3045F)**

OR

[ ] Most recent hemoglobin A1c level over 9.0% **(3046F)**

 # 110 DESCRIPTION: Current Season's Influenza Immunization

Numerator Options (Pick One) During October 1, 2018 and December 31, 2018

[ ] Yes, the patient got a flu shot this year **(G8482)**

OR

[ ] Nope, there is a medical reason for not giving flu shot or the patient refused **(G8483)**

OR

[ ] Nope, this person has not had a flu shot this year **(G8484)**

Cost - 2018

Episode-Based Cost Measures		Episode Count for Your TIN-NPI	Average Episode Risk Score Percentile	Cost Measure Score		Percent Difference Between Your TIN-NPI's Average Risk-Adjusted Episode Cost and National
Type	Name			Your TIN-NPI	National Average	
Procedural	Elective Outpatient PCI	-	-	-	$10,902	-
Procedural	Knee Arthroplasty	-	-	-	$19,172	-
Procedural	Revascularization For Lower Extremity Chronic Critical Limb Ischemia	-	-	-	$23,219	-
Procedural	Routine Cataract Removal with IOL Implantation	-	-	-	$2,676	-
Procedural	Screening/Surveillance Colonoscopy	119	84th	$902	$873	3%
Acute IP Medical Condition	Intracranial Hemorrhage Or Cerebral Infarction	-	-	-	$22,959	-
Acute IP Medical Condition	Simple Pneumonia with Hospitalization	-	-	-	$10,142	-
Acute IP Medical Condition	STEMI with PCI	-	-	-	$19,159	-

Quality – New for 2018

Appendix B: Episode-Level Table for All Episodes Attributed to Yo

Please see Appendix C for more information on the metrics presented in the table below.

Episode Group	Episode Information		Episode Costs			
	Episode ID	Episode Sub-Group (if applicable)	Observed (Non-Risk-Adjusted) Cost	Risk-Adjusted Cost	Risk-Adjusted Cost Percentile	Risk Score
Screening/Surveillance Colonoscopy	24545.0992	-	$1,352	$1,334	93rd	1.01
Screening/Surveillance Colonoscopy	24604.0922	-	$1,467	$1,401	94th	1.05
Screening/Surveillance Colonoscopy	24774.0702	-	$851	$809	43rd	1.05
Screening/Surveillance Colonoscopy	24819.0662	-	$1,389	$1,382	94th	1.00
Screening/Surveillance Colonoscopy	24882.1002	-	$1,131	$1,126	82nd	1.00
Screening/Surveillance Colonoscopy	25157.0202	-	$937	$951	60th	0.98
Screening/Surveillance Colonoscopy	25204.0802	-	$326	$314	3rd	1.04
Screening/Surveillance Colonoscopy	25369.0452	-	$197	$190	0th	1.03
Screening/Surveillance Colonoscopy	25625.0132	-	$1,150	$779	39th	1.48
Screening/Surveillance Colonoscopy	25636.0092	-	$521	$499	8th	1.04

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Alternative Payment Models (APM)

APMs give us new ways to pay health care providers for the care they give Medicare beneficiaries. For example:

1. From 2019-2024, pay **some participating health care providers** a lump-sum incentive payment.
2. Increased **transparency** of physician-focused payment models.
3. Starting in 2026, offers some participating health care providers **higher annual payments.**

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Accountable Care Organizations

An ACO is a group of providers—potentially including physicians, hospitals, post-acute providers, and others—who are collectively responsible for the care outcomes of a patient population.

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Shared Savings Program ACO Participation Options

The Shared Savings Program offers different participation options (tracks) that allow ACOs to assume various levels of risk.

Track	Financial Risk Arrangement	Description
1	One-sided	Track 1 ACOs do not assume downside risk (shared losses) if they do not lower growth in Medicare expenditures.
Medicare ACO Track 1+ Model*	Two-sided	Medicare ACO Track 1+ Model (Track 1+ Model) ACOs assume limited downside risk (less than Track 2 or Track 3).
2	Two-sided	Track 2 ACOs may share in savings or repay Medicare losses depending on performance. Track 2 ACOs may share in a greater portion of savings than Track 1 ACOs.
3	Two-sided	Track 3 ACOs may share in savings or repay Medicare losses depending on performance. Track 3 ACOs take on the greatest amount of risk, but may share in the greatest portion of savings if successful.

2018 ACCOUNTABLE CARE ORGANIZATION INFORMATION

ACO CHARACTERISTICS

	ACOs	Percent
Non-Risk Based:		
Track 1	460	82%
Risk Based:		
Track 1+ Model	55	10%
SNF 3-Day Rule Waiver	31	--
Track 2	8	1%
Track 3	38	7%
SNF 3-Day Rule Waiver	30	--

ACO COMPOSITION

	ACOs	Percent
Physicians Only	171	30%
Physicians, Hospitals, & Other Facilities	324	58%
FQHCs / RHCs	66	12%

ACO PARTICIPANT LIST COMPOSITION

Participant TINs	20,690
Physicians, PAs, NPs, CNSs	377,515
Hospitals	1,517
Federally Qualified Health Centers	2,560
Rural Health Centers	1,210
Critical Access Hospitals	421

SNF AFFILIATES (SNF 3-DAY RULE WAIVER)

SNFs	868

Still Have Four Measures

Quality – more measures –

but it's all providers doing this

Cost – only certain specialties

Promoting Interoperability – **on your own**

Advancing Care Information – **done by ACO**

Compass PTN Core Measures

Measure ID	Measure Name	Denominator	Numerator	NQS Domain	Measure Type/ QPP Priority Level	QPP Specialty Measure Set
NEW MEASURE eMeasure ID: N/A eMeasure NQF: N/A NQF: N/A QualityID: 402 **This measure is a TCPI Common Measure*	Tobacco Use and Help with Quitting Among Adolescents	All patients aged 12-20 years with a visit during the measurement period	Patients who were screened for tobacco use at least once within 18 months (during the measurement period or the six months prior to the measurement period) AND who received tobacco cessation counseling intervention if identified as a tobacco user	Community/ Population Health	Process	Allergy/Immunology Internal Medicine Cardiology Dermatology Emergency Medicine Gastroenterology General Surgery General Oncology Hospitalists Neurology Obstetrics/Gynecology Ophthalmology Orthopedic Surgery Otolaryngology Physical Medicine Preventive Medicine Rheumatology Thoracic Surgery Urology Vascular Surgery Mental/Behavioral Health Plastic Surgery General Practice Family Medicine Pediatrics
NEW MEASURE eMeasure ID: CMS2v6 eMeasure NQF: N/A NQF: 0418 QualityID: 134 **This measure is a TCPI Common Measure*	Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan	All patients aged 12 years and older	Patients screened for depression on the date of the encounter using an age appropriate standardized tool AND, if positive, a follow-up plan is documented on the date of the positive screen	Community/ Population Health	Process	Internal Medicine Mental/Behavioral Health General Practice Family Medicine Pediatrics

Tobacco Cessation Codes

The CPT Codes:

99406: Smoking and tobacco cessation counseling; intermediate, greater than 3 minutes, up to 10 minutes,

99407: Smoking and tobacco cessation counseling; intensive, greater than 10 minutes,

The Diagnosis Codes

- ICD-10 code F17.210 (dependent tobacco use disorder), or
- ICD-10 code Z87.891 (history of tobacco use).

If used with E/M, don’t forget modifier 25

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Annual Depression Screen

The HCPCS Code

G0444 - Annual Depression Screening – 15 minutes

ICD-10: **Z13.89**

Frequency: Annually

MCR Reimbursement: **$17.13**

Quality Measure

DM-7 Diabetes: Eye Exam

DESCRIPTION:
Percentage of patients 18 – 75 years of age with diabetes who had retinal or dilated eye exam by an eye care professional during the measurement period OR a negative retinal exam (no evidence of retinopathy) in the 12 months prior to the measurement period.

10. Determine if patient was screened for diabetic retinal disease identified by one of the following:

- A retinal or dilated eye exam by an eye care professional during the measurement period (2017)
  OR
- A negative retinal exam (no evidence of retinopathy) by an eye care professional in the year prior to the measurement period (2016)

The eye exam must be performed or reviewed by an ophthalmologist or optometrist
Alternatively, results may be read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist
For example, if an endocrinologist or PCP performs the appropriate imaging in their office and the results are reviewed by an eye care professional (optometrist or ophthalmologist) during the measurement period or the year prior to the measurement period (if negative for retinopathy) then it is eligible for use in reporting

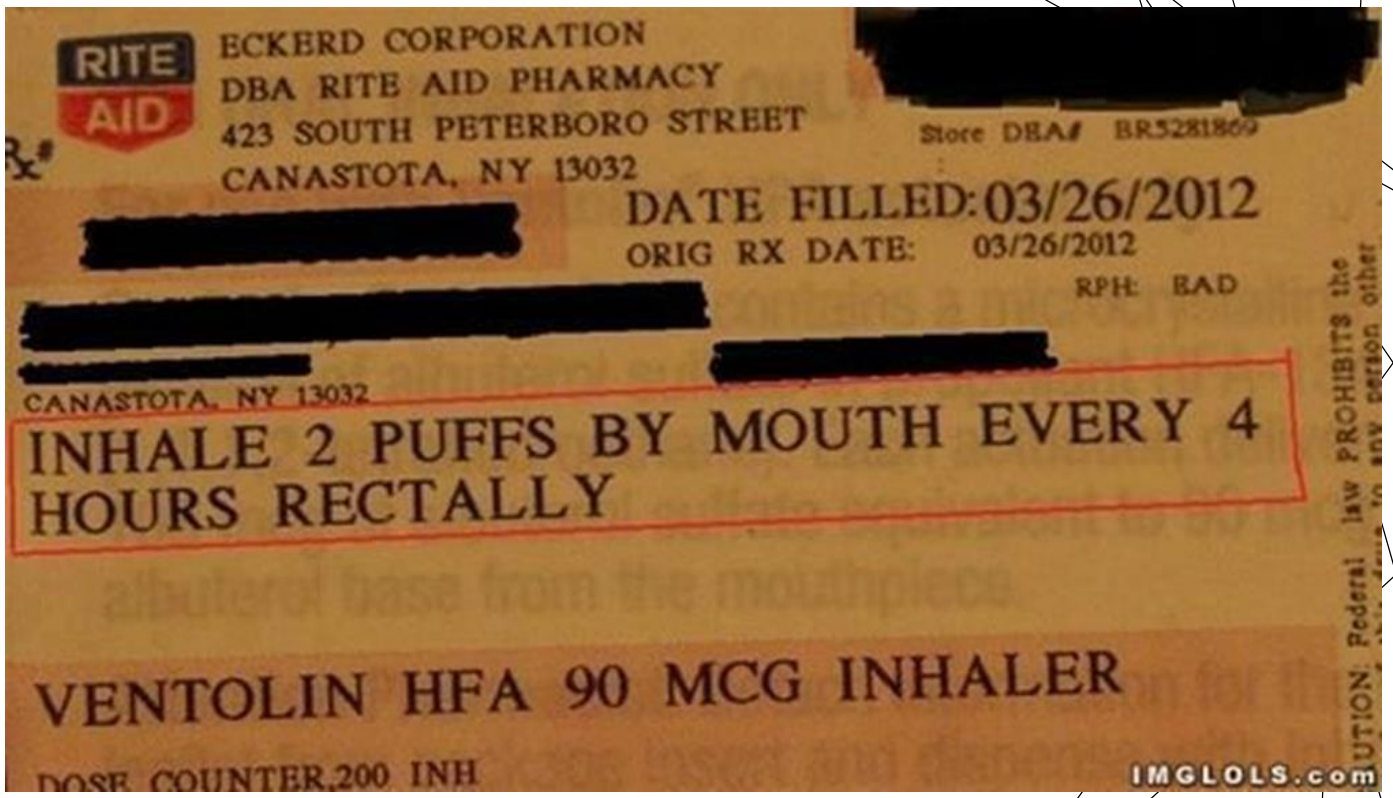
Note:

- ***Who****-The eye exam must be performed by an ophthalmologist or optometrist.*
- ***What****- The date of the retinal or dilated eye exam and results of the negative retinal exam if the exam was performed in the year prior to the measurement period. Patient reported data is acceptable as long as date (year) and result/finding are known and documented.*

- **YES (2)**
- **NO (1)**

At the end of the year, the ACO will have you “fill in gaps” that CMS state might be missing from specific patients assigned to your ACO – Good news is, several providers are also providing data that you might have overlooked

Clinically Integrated Networks



Clinically Integrated Network (CIN):

A CI program involves a network of otherwise **independent physicians** who collectively commit to quality and cost improvement. To support these efforts, physicians in the CI network may—under a "safe harbor" from antitrust law—negotiate collectively for commercial payer contracts, with joint contracting seen as "reasonably necessary" to support investment (of both time and resources) in performance improvement and ensure cross-referrals among participating providers.

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A clinically integrated network (CIN) and an accountable care organization (ACO) have similar goals, though they are structured in different ways.

This doesn’t mean they are mutually exclusive, however. In fact, a CIN often serves as the physician network arm of a larger ACO

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Like an ACO

You might have:

- Chronic Care Coordinators
- Prescription Drug Advocates
- Case managers for coding
- Transitional Care Coordinators
- Annual Well & Preventive Healthcare Staff

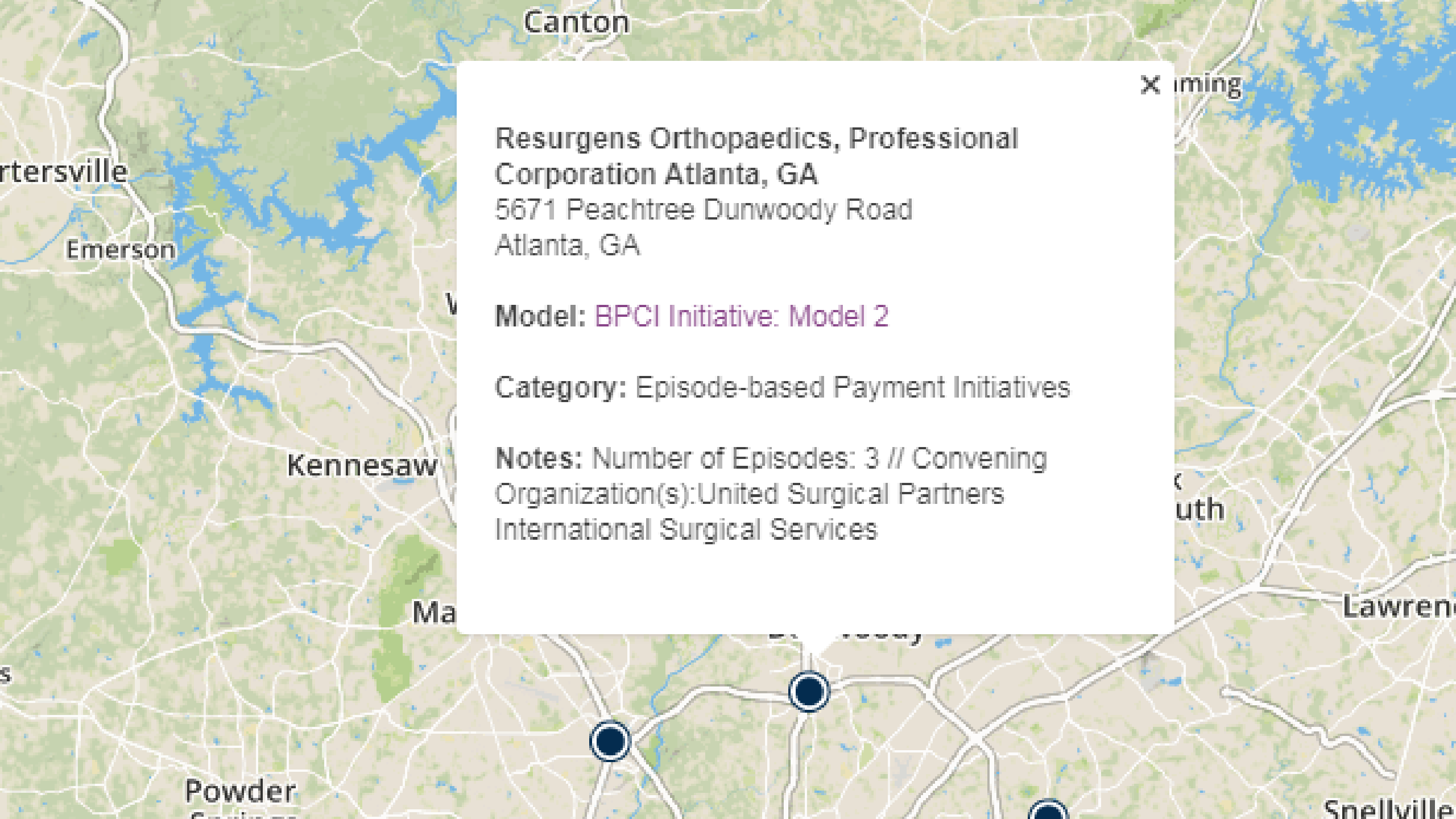
Bundled Payment Models

Bundled Payment Models

Payers typically set the bundled payment amount at the historical price for providing care to a patient undergoing a certain procedure or managing a specific condition. The historical price is typically adjusted for regional price variations and patient characteristics as well as discounted to promote cost reductions. – **Good for Surgeons**

Exhibit 10: Characteristics of the Matched BPCI Providers Included in the DiD Estimates, Model 2, Q4 2013 – Q3 2016

Clinical Episode	Matched EIs (#)	Matched Intervention Period Episodes (#)	Average Length of Participation (Quarters)	EIs that Terminated Participation in the Clinical Episode (%)	Episodes from EIs that Terminated (%)
Acute myocardial infarction	93	5,337	5	41%	36%
Cardiac arrhythmia	70	6,029	5	51%	45%
Cardiac valve	31	3,957	6	48%	53%
Cellulitis	79	5,474	5	43%	50%
Cervical spinal fusion	34	1,190	5	44%	34%
Congestive heart failure	173	31,858	5	30%	29%
COPD, bronchitis, asthma	133	18,331	6	31%	33%
Coronary artery bypass graft	43	3,242	6	28%	32%
Diabetes	45	1,423	5	38%	24%
Esophagitis, gastroenteritis & other digestive disorders	58	4,104	4	53%	48%
Fractures of the femur and hip or pelvis	47	1,092	5	34%	36%
Gastrointestinal hemorrhage	58	4,386	4	66%	51%
Gastrointestinal obstruction	51	1,735	4	53%	47%
Hip & femur procedures except major joint	101	7,446	5	36%	26%
Lower extremity and humerus procedure except hip, foot, femur	37	1,089	6	38%	28%
Major bowel procedure	46	3,029	5	39%	37%
Major joint replacement of the lower extremity	303	97,922	6	19%	14%
Major joint replacement of the upper extremity	26	1,337	5	31%	21%
Medical non-infectious orthopedic	94	6,588	5	43%	35%
Nutritional and metabolic disorders	57	2,727	4	47%	51%
Other respiratory	62	4,700	5	42%	32%
Other vascular surgery	36	1,590	5	44%	38%
Percutaneous coronary intervention	45	4,745	5	24%	23%



Resurgens Orthopaedics, Professional Corporation Atlanta, GA
5671 Peachtree Dunwoody Road
Atlanta, GA

Model: BPCI Initiative: Model 2

Category: Episode-based Payment Initiatives

Notes: Number of Episodes: 3 // Convening Organization(s):United Surgical Partners International Surgical Services

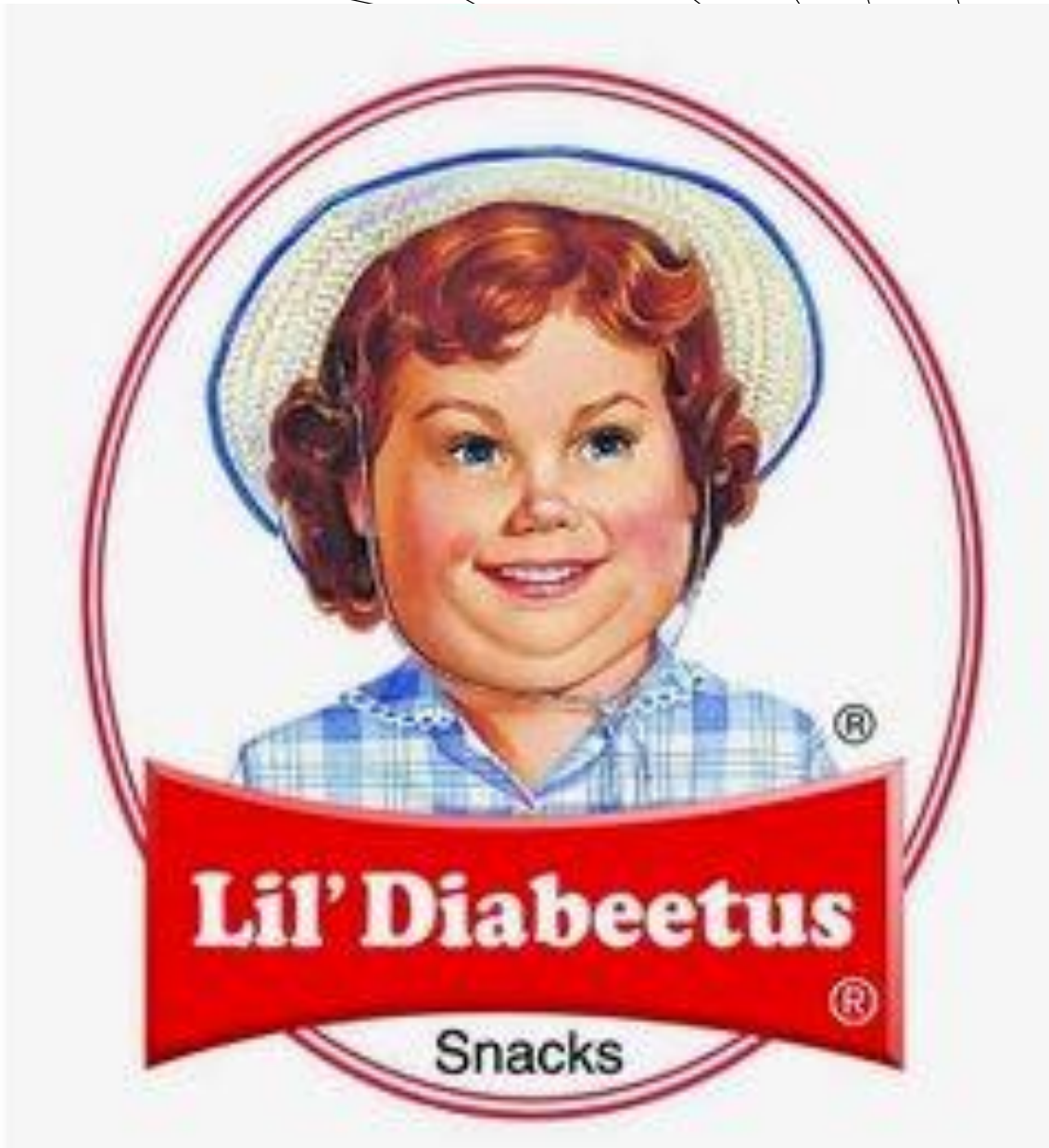
CMS Findings

*We observed a statistically significant decline in Medicare allowed payments for **five** ACH initiated Model 2 clinical episodes: transient ischemia, MJRLE, medical non-infectious orthopedic, hip and femur procedures except major joint, and urinary tract infection.*

In the Year 3 annual report, based on the first two years of the initiative, only MJRLE had a statistically significant decline in Medicare allowed payments. The average reduction in Medicare payments across these five clinical episodes was 6.7% greater than what we would have expected without BPCI.

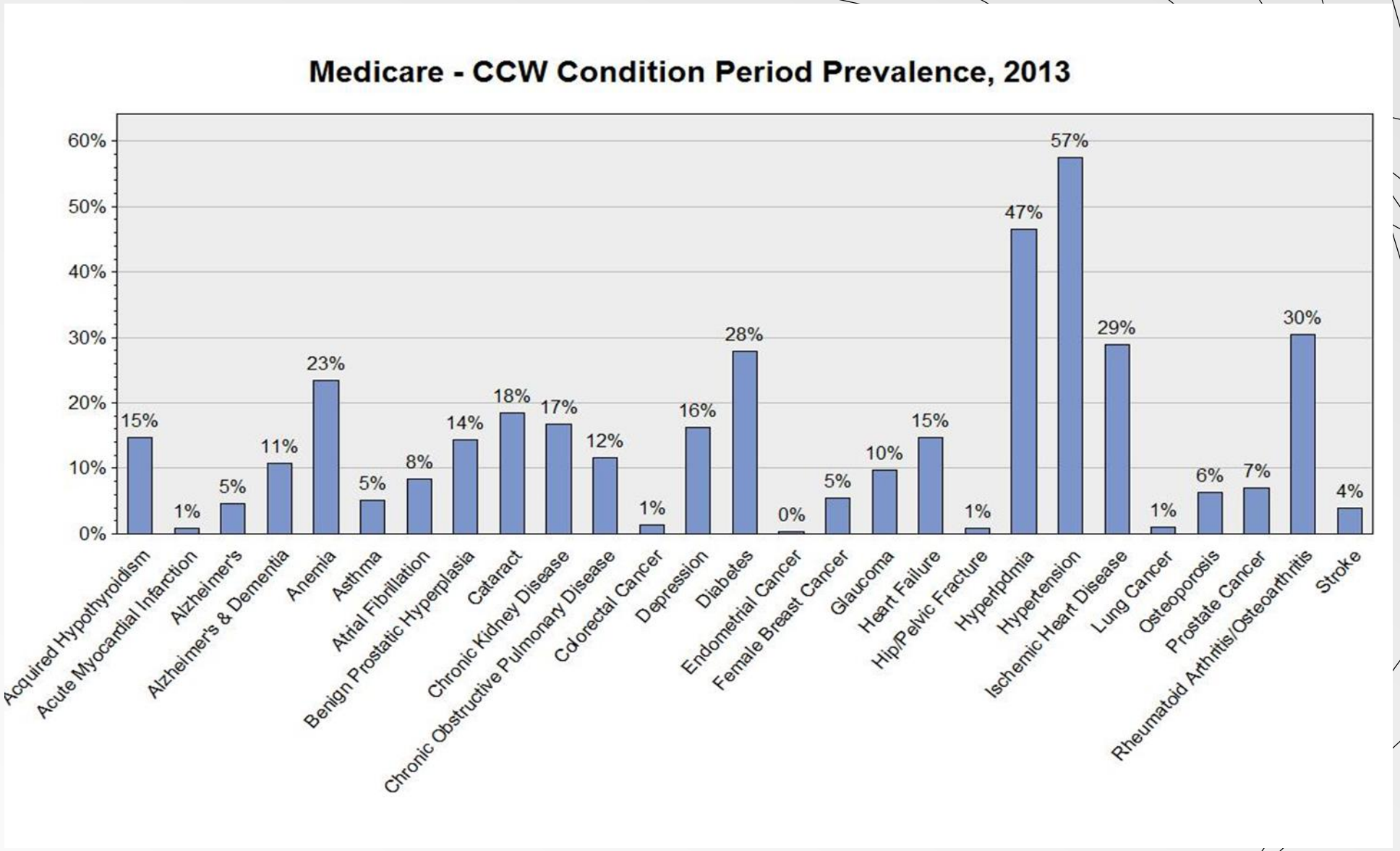
The statistically significant declines in total payments for the inpatient stay and 90 day post-discharge period were driven by a reduction in PAC utilization, particularly IRF and SNF use…

HCC and Risk Adjustment Models



HCC/Risk Adjustment Factor

This allows insurance companies an opportunity to forecast future expenditures on each patient within the risk model.


Medicare - CCW Condition Period Prevalence, 2013
60%
50%
40%
30%
20%
10%
0%
15%
1%
5%
11%
23%
5%
8%
14%
18%
17%
12%
1%
16%
28%
0%
5%
10%
15%
1%
47%
57%
29%
1%
6%
7%
30%
4%
Acquired Hypothyroidism
Acute Myocardial Infarction
Alzheimer's
Alzheimer's & Dementia
Anemia
Asthma
Atrial Fibrillation
Benign Prostatic Hyperplasia
Cataract
Chronic Kidney Disease
Chronic Obstructive Pulmonary Disease
Colorectal Cancer
Depression
Diabetes
Endometrial Cancer
Female Breast Cancer
Glaucoma
Heart Failure
Hip/Pelvic Fracture
Hyperlpdmia
Hypertension
Ischemic Heart Disease
Lung Cancer
Osteoporosis
Prostate Cancer
Rheumatoid Arthritis/Osteoarthritis
Stroke

HCC

What is an HCC code?

The HCC model is made up of 9,000 ICD-10 codes that typically represent costly, **chronic** diseases such as:

- Diabetes
- Chronic kidney disease
- Congestive heart failure
- Chronic obstructive pulmonary disease
- Malignant neoplasms
- Some acute conditions (MI, CVA, hip fx)

How It Works:

HCC (Hierarchical Condition Category)

- Per CMS, the diagnosis codes are recorded per year, meaning each condition must be documented and coded each year.
- Diagnoses that demonstrate similar resource usage are categorized together.
- CMS designed the equation so that the average Medicare FFS patient has the score of **1.00**.

E11.9 ICD-10

19 HCC

RAF
Score = .105

Equation

Add Up the total RAF score at the end of the year for a patient (don’t double dip)

Multiply by the conversion factor

.4 x 9,000 = 3,600

Typical Southern Medicare Patient

- HTN- I10 Risk Score = 0
- DM – E11.9 Risk Score = .105
- HPL – E78.2 Risk Score = 0
- 65 Y/O male Risk Score = .307

0.4

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Goal

1.0 - 2.0

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RAF	HCC	DX	HYPERTENSION
0	NA	I10	Essential (primary) hypertension, stable
	HTN AND HEART DISEASE		
0.345	85	I110	Hypertensive heart disease with heart failure *Use additional code for heart failure*
0	NA	I119	Hypertensive heart disease without heart failure
	HTN AND CKD		
0.288	136	I120	Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease *Use additional code for CKD*
0	NA	I129	Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease *Use additional code for CKD*
	HTN AND HEART DISEASE AND CKD		
0	NA	I130	Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease *Use additional code for heart failure* *Use additional code for CKD*
0	NA	I1310	Hypertensive heart and chronic kidney disease without heart failure, with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease *Use additional code for CKD*
0.288	136	I1311	Hypertensive heart and chronic kidney disease without heart failure, with stage 5 chronic kidney disease, or end stage renal disease *Use additional code for CKD*
0.288	136/85	I132	Hypertensive heart and chronic kidney disease with heart failure, with stage 5 chronic kidney disease, or end stage renal disease *Use additional code for heart failure* *Use additional code for CKD*

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RAF	HCC	DX	TYPE 2 DIABETES MELLITUS
0.105	19	E119	Type 2 diabetes mellitus without complications
	TYPE 2 DM WITH KIDNEY COMPLICATIONS		
0.305	18	E1121	with diabetic nephropathy
0.305	18	E1122	with diabetic chronic kidney disease *Use additional code for CKD*
0.305	18	E1129	with other diabetic kidney complication
	TYPE 2 DM WITH NEUROLOGICAL COMPLICATIONS		
0.305	18	E1140	with diabetic neuropathy, unspecified
0.305	18	E1141	with diabetic mononeuropathy
0.305	18	E1142	with diabetic polyneuropathy
0.305	18	E1143	with diabetic autonomic (poly)neuropathy
0.305	18	E1149	with other diabetic neurological complication
	TYPE 2 DM WITH CIRCULATORY COMPLICATIONS		
0.305	18	E1151	with diabetic peripheral angiopathy without gangrene
0.305	18	E1152	with diabetic peripheral angiopathy with gangrene
0.305	18	E1159	with other circulatory complications
	TYPE 2 DM WITH OTHER COMPLICATIONS		
0.305	18	E11610	with diabetic neuropathic arthropathy
0.305	18	E11620	with diabetic dermatitis
0.305	18	E11621	with foot ulcer *Use additional code for foot ulcer - L97 series -*
0.305	18	E11622	with other skin ulcer
0.305	18	E11628	with other skin complications
0.305	18	E11630	with periodontal disease
0.305	18	E11638	with other oral complications
0.305	18	E11649	with hypoglycemia without coma
0.305	18	E1165	with hyperglycemia
0.305	18	E1169	with other specified complication
0.105	19	Z794	Long term (current) use of insulin

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RAF	HCC	DX	CHRONIC KIDNEY DISEASE
0	NA	N181	Stage 1, CKD
0	NA	N182	Stage 2, CKD
0	NA	N183	Stage 3, CKD
0.288	137	N184	Stage 4, CKD
0.288	136	N185	Stage 5, CKD
0.288	136	N186	Stage 6, CKD

RAF	HCC	DX	DIALYSIS
0.456	134	Z992	Dependence on renal dialysis
0.456	134	Z9115	Patient's noncompliance with renal dialysis

A patient with Hypertension is seen in a provider's office. The patient also has stage 4 CKD, uncontrolled DM and is currently taking insulin. The patient's BMI is 40 and has a history of left great toe amputation because of uncontrolled DM. Currently the patient is Alcohol Dependent, in remission.

A patient with Hypertension is seen in a provider's office. The patient also has stage 4 CKD, uncontrolled DM and is currently taking insulin. The patient's BMI is 40 and has a history of left great toe amputation because of uncontrolled DM. Currently the patient is Alcohol Dependent, in remission.

TABLE 1

Diagnosis	**Diagnosis ICD-10**	**HCC**	**RAF**	**Projected Expenditures**
Hypertension	I10	NA	0	0
DM, Controlled	E11.9	19	0.105	$983.57
Future Expenditures			0.105	$983.57

A patient with Hypertension is seen in a provider's office. The patient also has stage 4 CKD, uncontrolled DM and is currently taking insulin. The patient's BMI is 40 and has a history of left great toe amputation because of uncontrolled DM. Currently the patient is Alcohol Dependent, in remission.

TABLE 2

Diagnosis	**Diagnosis ICD-10**	**HCC**	**RAF**	**Projected Expenditures**
Hypertension with Stage 4 CKD	I12.9	NA	0	
Stage 4 CKD	N18.4	137	.288	
Uncontrolled DM	E11.65	18	.305	
Alcohol Dependence in Remission	F10.21	55	.344	
Long Term Use of Insulin	Z79.4	19	.105	Can't bill a 19 and 18 together
Acquired Absence of Great Toe	Z89.412	189	.521	
BMI of 40	Z68.41	22	.244	
Future Expenditures			1.702	$15,943.21

Final Thoughts I Share With My Clients

Three Questions

What Percentage of the Shared Savings do You Share with your Providers?

Who Pays Me?

Who Controls My Patients?

Discussion Points

1. Quality Payment Program (QPP)
2. Accountable Care Organizations (ACO)
3. Clinically Integrated Network (CIN)
4. Bundled Payment Models (BPM)
5. Risk Adjustment Models (HCC and RAF)

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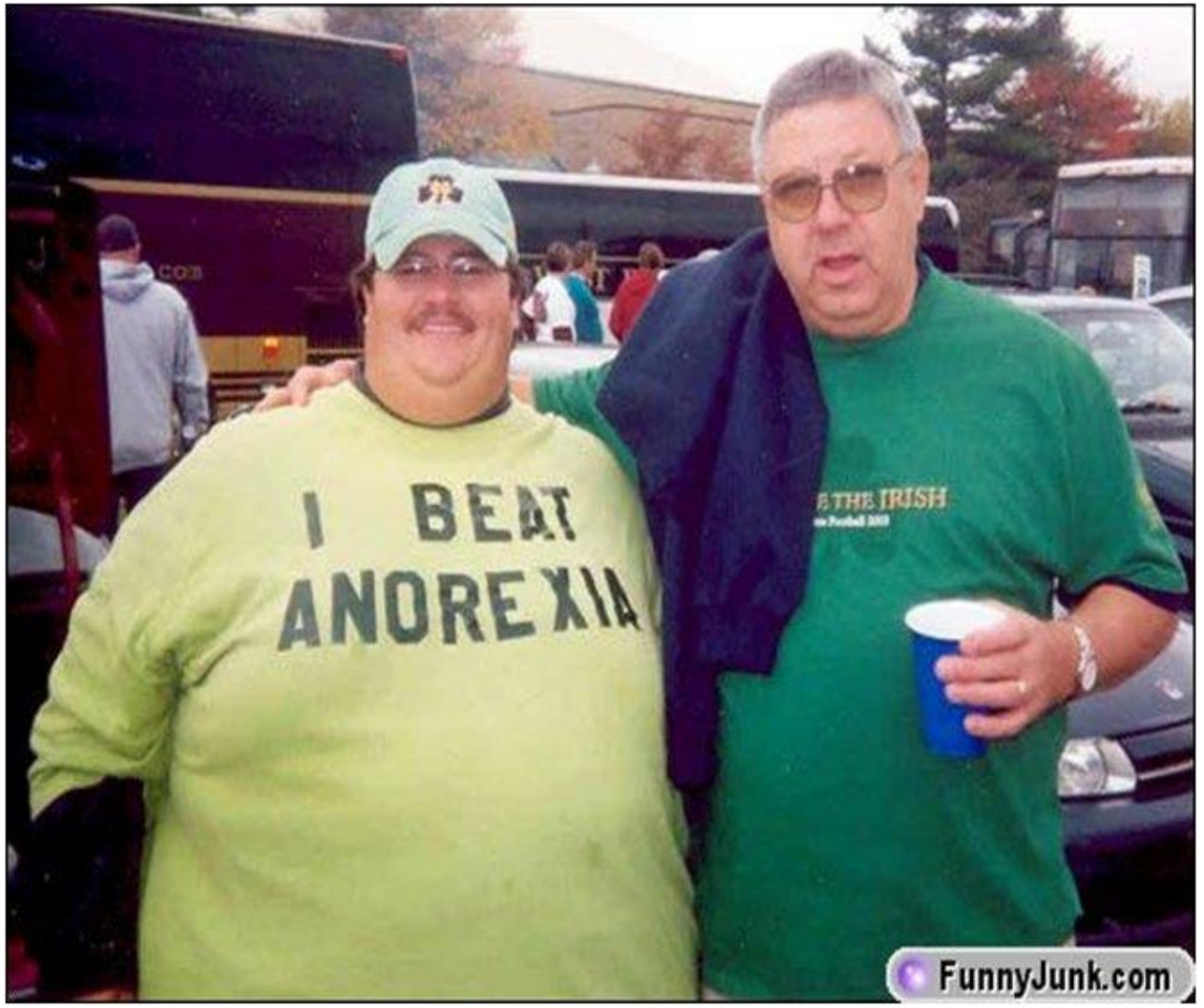
Questions?



Any Questions

Direct:	706-483-4728
E-Fax:	770-709-3698
E-mail:	steve.adams@inhealthps.com
Web:	www.thecodingeducator.com
Twitter:	@thekingofcoders
Instagram:	kingofcoders
Facebook:	facebook.com/kingofcoders

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COMPASS
Practice Transformation Network

SANFORD HEALTH
Transforming Clinical Practice Initiative (TCPI)

Georgia Learning Community

Tessi Ross, BSN, MPA, RN, CPHQ

August 11, 2018

TCPI Disclaimer

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Introduction to Sanford Health

COMPASS PTN partner organization

SANFORD HEALTH TODAY

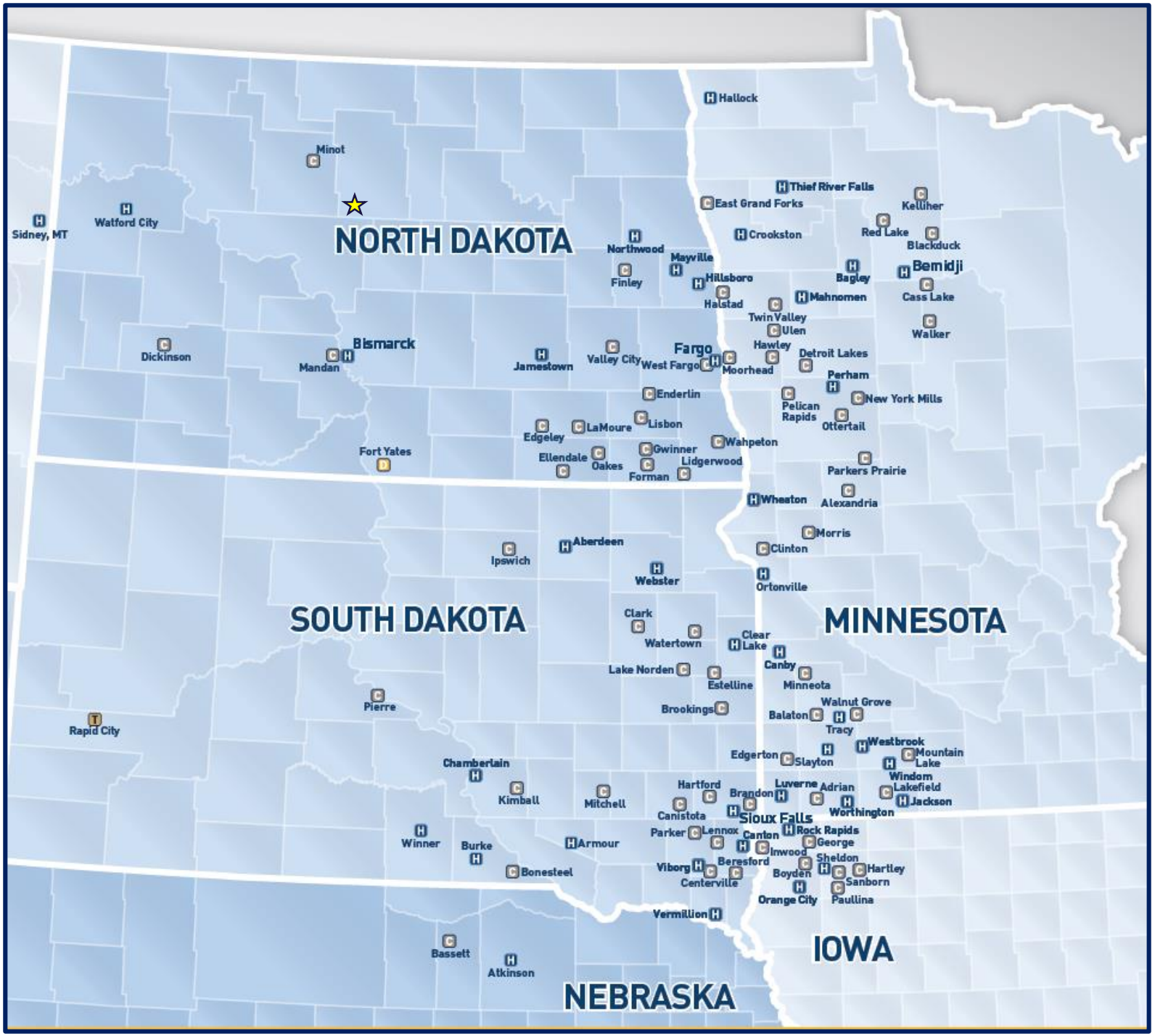
Serving 2.74 million people in 300 communities across 252,215 square miles in nine states and four countries.

- 44 medical centers
- $4.4 billion in annual revenue
- 291 clinics
- 48 senior living facilities
- 179,598 Sanford Health Plan Members
- 1,360 physicians, 921 advance practice providers and 6,348 registered nurses delivering care in more than 80 specialty areas
- 28,334 employees

Health Service Delivery Area World Clinics Profile Stores

Each year, Sanford provides:

- 5.3 million outpatient and clinic visits
- 81,637 admissions
- 159,032 surgeries and procedures
- 9,465 births
- 214,236 emergency department visits


NORTH DAKOTA
SOUTH DAKOTA
MINNESOTA
IOWA
NEBRASKA
Hallock
Minot
Thief River Falls
East Grand Forks
Kelliher
Watford City
Sidney, MT
Crookston
Red Lake
Blackduck
Northwood
Mayville
Bemidji
Finley
Hillsboro
Bagley
Halstad
Mahnomen
Cass Lake
Twin Valley
Ulen
Walker
Dickinson
Bismarck
Mandan
Jamestown
Valley City
Fargo
West Fargo
Moorhead
Hawley
Detroit Lakes
Perham
Enderlin
Pelican Rapids
New York Mills
Ottertail
Edgeley
LaMoure
Lisbon
Wahpeton
Fort Yates
Ellendale
Oakes
Gwinner
Lidgerwood
Forman
Parkers Prairie
Wheaton
Alexandria
Morris
Aberdeen
Ipswich
Clinton
Webster
Ortonville
Clark
Watertown
Clear Lake
Canby
Lake Norden
Estelline
Minneota
Pierre
Brookings
Walnut Grove
Balaton
Tracy
Rapid City
Westbrook
Edgerton
Slayton
Mountain Lake
Windom
Chamberlain
Hartford
Luverne
Adrian
Lakefield
Kimball
Mitchell
Brandon
Jackson
Canistota
Sioux Falls
Worthington
Winner
Parker
Lennox
Rock Rapids
Canton
George
Burke
Armour
Inwood
Sheldon
Viborg
Beresford
Hartley
Bonesteel
Centerville
Boyden
Sanborn
Orange City
Paullina
Vermillion
Bassett
Atkinson

Sanford COMPASS Team

Sanford Health Leadership

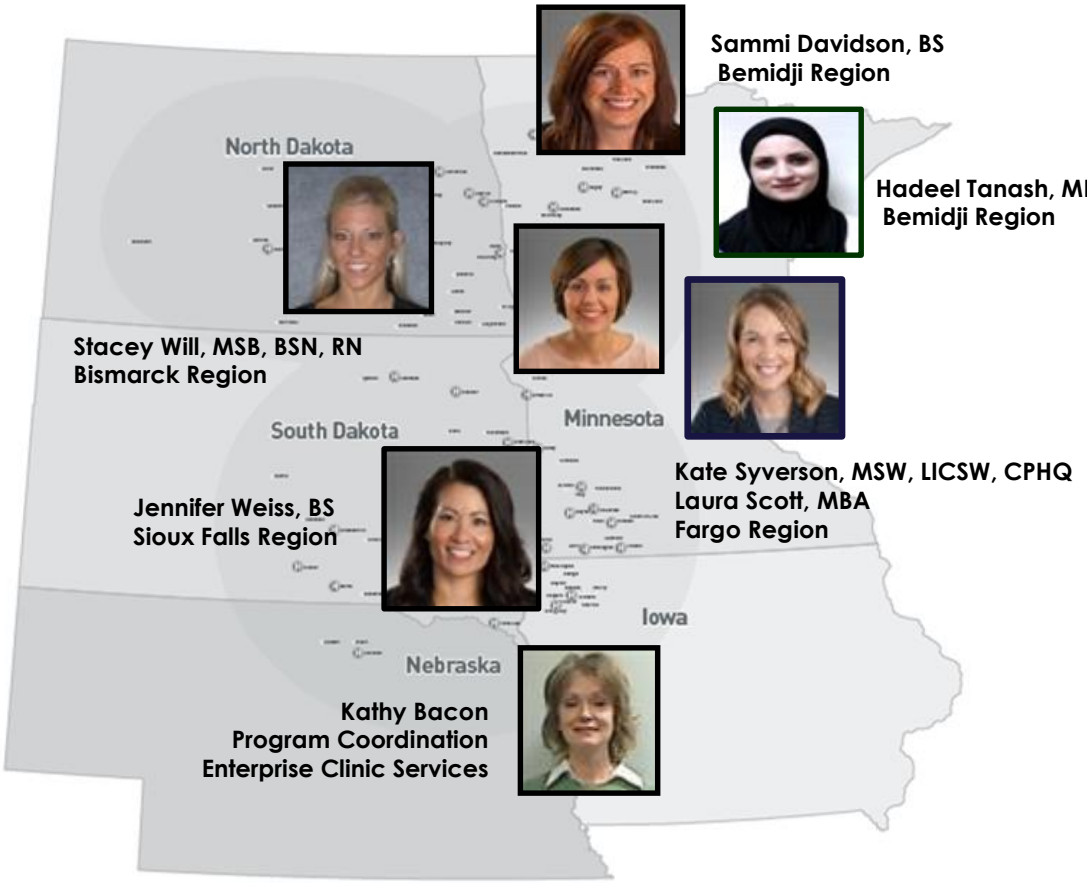
Molly Clark, MHA, PharmD
Co-Program Manager

Dan Heinemann, MD
Clinical Lead

Tessi Ross, MPA, BSN, RN, CPHQ
Program Manager

Taylor Slack, MS
Quality Strategist

Clinic Improvement Advisors



Sammi Davidson, BS
Bemidji Region

Hadeel Tanash, MPH, RN
Bemidji Region

Stacey Will, MSB, BSN, RN
Bismarck Region

Kate Syverson, MSW, LICSW, CPHQ
Laura Scott, MBA
Fargo Region

Jennifer Weiss, BS
Sioux Falls Region

Kathy Bacon
Program Coordination
Enterprise Clinic Services

COMPASS
Practice Transformation Network

Sanford Network Information

- 284 total practices
  - 113 Primary Care practices
  - 171 Specialty practices
- 1592 enrolled providers in 4 states
  - All Sanford employees
- Enterprise Clinic & Physician Leadership sets organizational goals and initiatives
- Regional and local leaders manage operations and align to organizational strategy

Our Transformation Approach

Strategic Plan:
Performance Improvement (PI) Plans
Clinic and Clinical Services Strategic Plans

- We develop annual PI plans for each market including Hospital and Ambulatory measures.
- How do we select measures?
  - Based on improvement needs in the areas of patient care, patient safety, and patient experience.
  - Consistent with local, regional, and national quality agendas.
  - Analyze payer data to determine opportunities
  - Data driven and leadership supported
- Strategic Initiatives selected at enterprise level
- Clinic and Clinical Services Strategic Plans

TCPI AIMS/GOALS

1.) Support clinicians in their practice transformation work
2.) Build evidence on practice transformation so that effective solutions can be scaled
3.) Improve health outcomes for millions of Medicare, Medicaid, and CHIP beneficiaries and other patients
4.) Reduce unnecessary hospitalizations
5.) Sustain efficient care delivery by reducing unnecessary testing and procedures
6.) Generate cost savings to the federal government and commercial payers
7.) Transition practices into Alternative Payment Models

PRIMARY DRIVERS

Patient & Family-Centered Care

SECONDARY DRIVERS/ TACTICS

Workflow Redesign
-Rooming Standardization
-Co-Visits

Team-Based Care
-Daily Huddles w/team
-Behavioral Health Integration
-Pharmacy Integration

Population Health Registries
-Preventative Screenings
-Chronic Disease
-Rising-Risk & High-Risk

Care Management Strategy

Advance Care Planning

Self-Management Programs
-Diabetes Prevention
-Better Choice Better Health

Sanford Experience
-Real-time Feedback
-Leader Rounding Strategy
-Communication & Empathy Training
-PFAC Strategy
-Retrospective Surveys

EMR Integration & Patient Portal Access

Mental Health First Aid

Continuous, Data-Driven Quality Improvement

Annual Performance Improvement (PI) Plans

Clinic Quality Dashboard
-Provider & Practice level data transparency
-Standard Patient Attribution Methodology

Physician & Executive Portals

Clinic Visibility Boards

Improvement Advisors

Quality Strategy Team

Sanford Improvement Model

Sanford Improvement Academy
-PI Boot Camps
-Leading For Improvement

Clinical Standardization
-Clinical Practice Guidelines
-Standard Treatment Regimens
-Nurse driven protocols

Value Improvement Workgroups
-Clinical Excellence

Sustainable Business Operations

Operational Performance Review

Payer Program Alignment

AMGA Staffing Mix Improvement

Same Day at Sanford & Family Medicine Walk-In Strategy

Alternative Visit Types
-E-visits, Video visits, group visits

Care Management Strategy

Post-Acute Care Coordination

TCM & Post-discharge follow up

Standard Annual Budget Process

Recognition Toolkit

Employee of the Year

Annual Nursing Awards

Daily Nurse Award (Clinics)

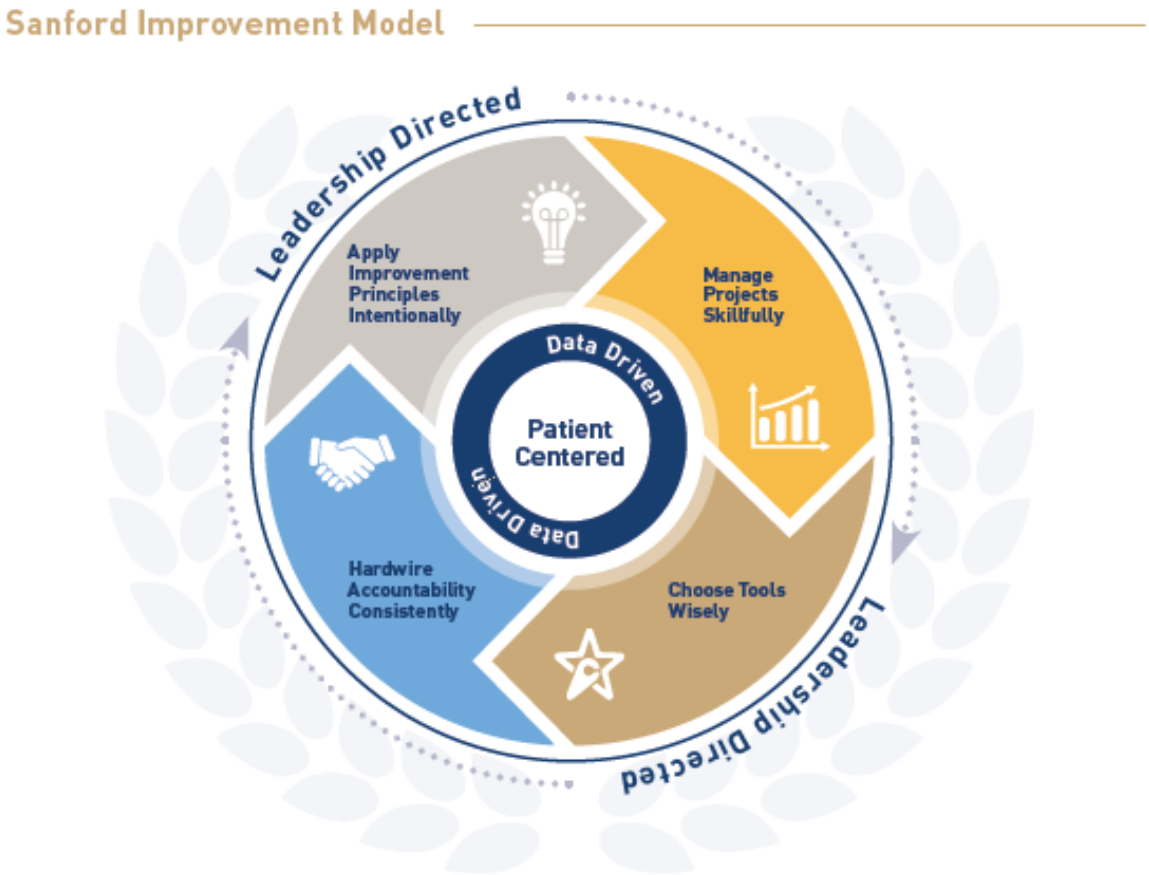
Hero Awards

New Revenue Sources

Data Transparency

- Prioritize internal data availability for PI plan measures
- Quality Dashboard
- Visibility Boards
- Executive and Physician Portal
- Sanford Improvement Symposiums
- Epic Dashboards (future state)

Sanford Improvement Model



Improvement Advisor Role

- Partner with leadership to organize, assist, and coordinate planning and implementation of improvement strategies
- Engage with clinic care teams to enhance awareness of quality measures, develop improvement strategies and spread best practices
- Collaborate and coach leaders throughout the organization on improvement principles/methodology

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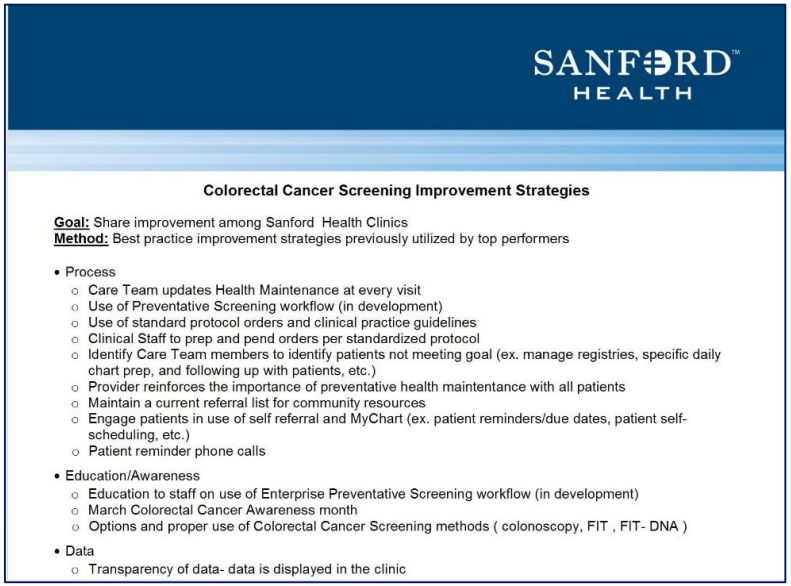
Practice Transformation Network

Improvement Strategies

- Measure Education and Improvement Strategy Documents
  - Hypertension Control
  - Optimal Diabetes Care
  - Optimal Vascular Care
  - Optimal Asthma Control
  - Asthma Education and Self-Management
  - BMI Screening & Follow-up Plan
  - Depression Remission at 6 & 12 months
  - Depression Screening & Follow-up Plan
  - Breast Cancer Screening
  - Colorectal Cancer Screening
  - Cervical Cancer Screening



SANFORD HEALTH

Colorectal Cancer Screening Improvement Strategies

Goal: Share improvement among Sanford Health Clinics
Method: Best practice improvement strategies previously utilized by top performers

- Process
  - Care Team updates Health Maintenance at every visit
  - Use of Preventative Screening workflow (in development)
  - Use of standard protocol orders and clinical practice guidelines
  - Clinical Staff to prep and pend orders per standardized protocol
  - Identify Care Team members to identify patients not meeting goal (ex. manage registries, specific daily chart prep, and following up with patients, etc.)
  - Provider reinforces the importance of preventative health maintentance with all patients
  - Maintain a current referral list for community resources
  - Engage patients in use of self referral and MyChart (ex. patient reminders/due dates, patient self-scheduling, etc.)
  - Patient reminder phone calls
- Education/Awareness
  - Education to staff on use of Enterprise Preventative Screening workflow (in development)
  - March Colorectal Cancer Awareness month
  - Options and proper use of Colorectal Cancer Screening methods (colonoscopy, FIT , FIT- DNA)
- Data
  - Transparency of data- data is displayed in the clinic

Success Stories

Hypertension Control & Depression Remission

Excellence in Hypertension Control

Sanford and COMPASS PTN goal:

- ✓Improve Hypertension Control (<140/90)
- ✓Collaborate with clinic teams to assess current state; develop, educate and implement best practices; monitor improvements to achieve and sustain high-performance

<u>Sanford Journey:</u>

- Began our initiative in 2013-2014
- Blood Measure Measurement Standardization
  - Started in a single regional market (Fargo), spread to all markets by the beginning of 2015
  - Education to front-line clinical staff on the importance of obtaining accurate blood pressure measurements
  - Implementation of standard process for blood pressure measurement to ensure accuracy of measurements across all clinics
  - Implementation of the blood pressure measurement algorithms in all clinics
- Future interventions became more robust and widespread
- <u>Lessons learned:</u> Start small, then spread; Start with one change

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Practice Transformation Network

Hypertension Control Interventions

- Use of Clinical Practice Guidelines and RN Protocols for Hypertension treatment
- Development/utilization of Healthy Planet patient registry in our electronic medical record to identify individuals not meeting hypertension goals and initiate patient outreach
- Real-time notification of patients not meeting optimal goals (i.e. EMR Best Practice Alerts, huddles)
- Identify patients who are not reaching optimal care goals and who are appropriate for health coaching taking into account patient readiness
  - Utilization of Motivational Interviewing, working with patient to develop goals
  - Development and personalization of a care plan with patient and family (when appropriate)
  - Consideration of depression and/or behavioral health screening tools or IHT referral
  - Addressing substance abuse concerns
  - Identification of appropriate care team members to follow-up with patients not meeting goal
- Aggressive treatment and targeting of patients who are close to goal
- Drawing lab work prior to appointments
- Personalizing follow-up treatment plans when goals not met
- Scheduling follow-up appointments prior to leaving the clinic
- Data transparency

Hypertension Control Performance

- 2017 Million Hearts Hypertension Control Champion by the CDC & CMS
- 86.11% in 2015 and now at 88.6% in 2018 (d=153,129)
  - Improved HTN control for over 5,000 patients
  - Better control of blood pressure has been shown to significantly reduce the probability that undesirable and costly outcomes occur
    - Stroke, MI, Heart Failure
- Decision to stay at 140/90 for internal clinical practice guidelines

Health & Wellness Strategy: Depression Toolkit

Collective obligation to provide our patients with pathways to achieving a positive lifestyle

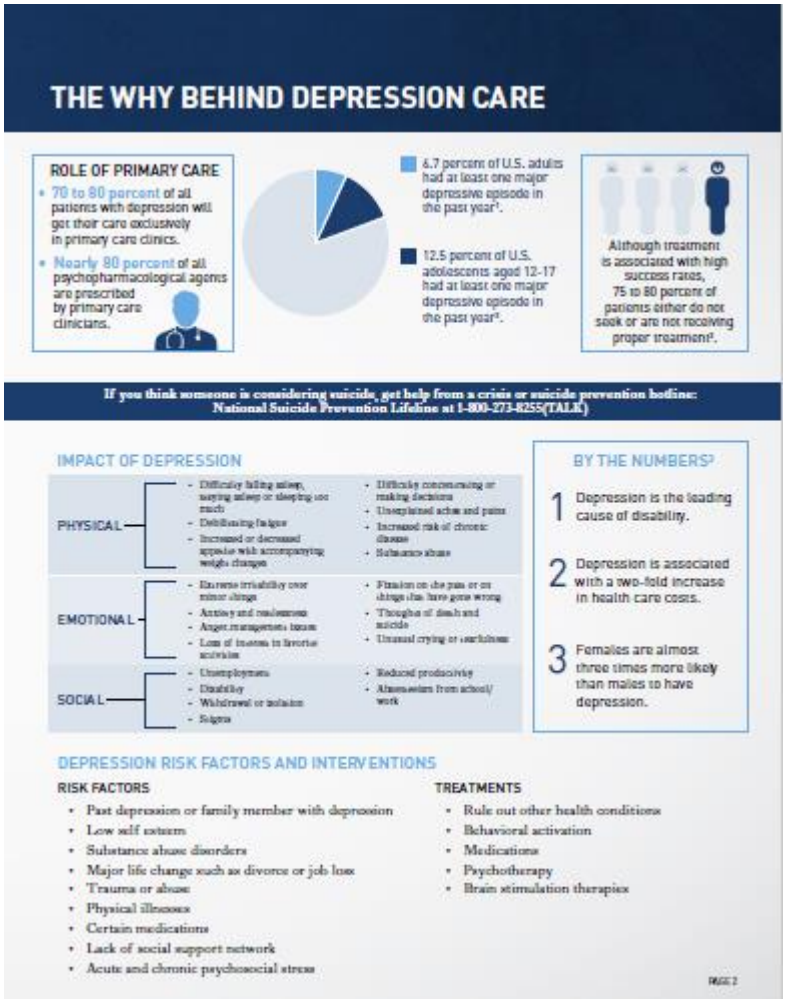
- Screen
- Diagnosis
- Treat
- Reassess

*At Sanford Health, approximately **7.83%** (n=47,779) adult patients aged 18+ had an encounter dx of major depression in the past year*

COMPASS
Practice Transformation Network

Health & Wellness Strategy
Depression Toolkit

1) Understand the Why
2) Measurement Overview
3) Diagnostic Precision
4) Improvement Strategies
5) Clinical Practice Guidelines
6) Patient Engagement
7) Cross-Cultural Considerations



THE WHY BEHIND DEPRESSION CARE

ROLE OF PRIMARY CARE

- 70 to 80 percent of all patients with depression will get their care exclusively in primary care clinics.
- Nearly 80 percent of all psychopharmacological agents are prescribed by primary care clinicians.

6.7 percent of U.S. adults had at least one major depressive episode in the past year[1].

12.5 percent of U.S. adolescents aged 12-17 had at least one major depressive episode in the past year[1].

Although treatment is associated with high success rates, 75 to 80 percent of patients either do not seek or are not receiving proper treatment[2].

If you think someone is considering suicide, get help from a crisis or suicide prevention hotline: National Suicide Prevention Lifeline at 1-800-273-8255(TALK)

IMPACT OF DEPRESSION

PHYSICAL
- Difficulty falling asleep, staying asleep or sleeping too much
- Debilitating fatigue
- Increased or decreased appetite with accompanying weight changes
- Difficulty concentrating or making decisions
- Unexplained aches and pains
- Increased risk of chronic disease
- Substance abuse

EMOTIONAL
- Extreme irritability over minor things
- Anxiety and restlessness
- Anger management issues
- Loss of interest in favorite activities
- Fixation on the past or on things that have gone wrong
- Thoughts of death and suicide
- Unusual crying or tearfulness

SOCIAL
- Unemployment
- Disability
- Withdrawal or isolation
- Stigma
- Reduced productivity
- Absenteeism from school/work

BY THE NUMBERS[2]

1 Depression is the leading cause of disability.

2 Depression is associated with a two-fold increase in health care costs.

3 Females are almost three times more likely than males to have depression.

DEPRESSION RISK FACTORS AND INTERVENTIONS

RISK FACTORS
- Past depression or family member with depression
- Low self esteem
- Substance abuse disorders
- Major life change such as divorce or job loss
- Trauma or abuse
- Physical illnesses
- Certain medications
- Lack of social support network
- Acute and chronic psychosocial stress

TREATMENTS
- Rule out other health conditions
- Behavioral activation
- Medications
- Psychotherapy
- Brain stimulation therapies

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Results

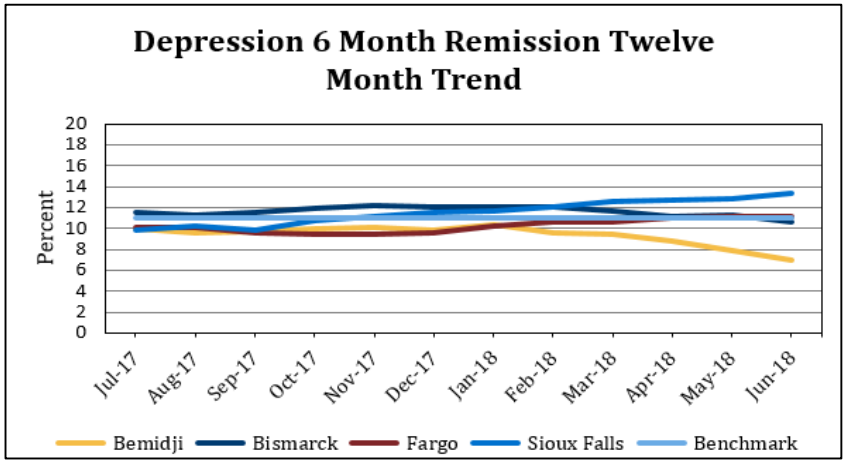
Enterprise Rates Improved for both measures:

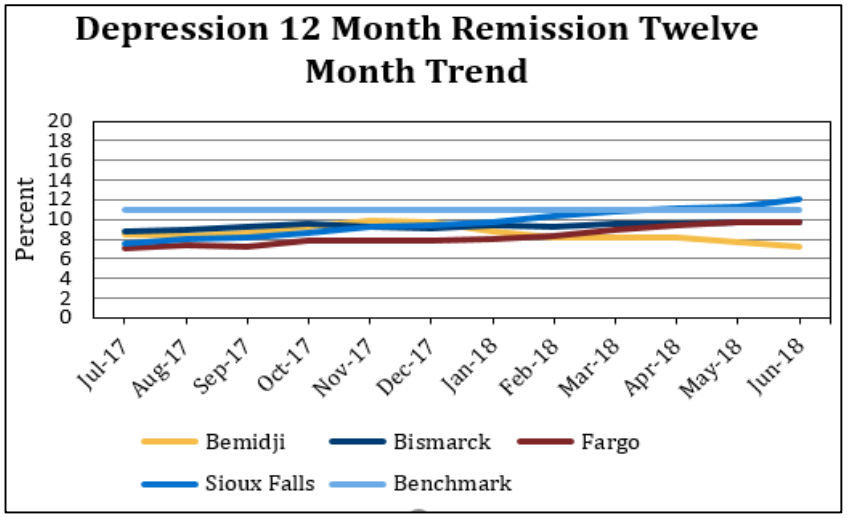
	Jun-16	Jun-17	June-18
6 Month Remission	8.02%	10.80%	11.3%
12 Month Remission	N/A	7.45%	10.2%

6 months:
June 2016 (968/12071)
June 2017 (1257/12343)
June 2018 (1237/10919)

12 months:
June 2017 (868/11578)
June 2018 (992/9709)

*Note the decline in denominator = due to improved diagnostic precision and change to ICD10





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WE'VE GOT YOUR BACK SIDE

Sammi Davidson, BS, Improvement Advisor, Sanford Health; Tessi Ross, BSN, MPA, RN, CPHQ, Senior Quality Strategist, Sanford Health

SANFORD HEALTH

Learning Objectives

- Describe our commitment to the National Colorectal Cancer Roundtable 80% by 2018 initiative
- Recognize system and clinical improvement strategies to increase colorectal cancer screening rates
- Evaluate results in performance

Objective

Sanford Health will reach 80% in colorectal cancer screening rates by Dec. 31, 2018 in alignment with the National Colorectal Cancer Roundtable initiative.

Background

Colorectal cancer is the second leading cause of cancer death for men and women in the United States and has become a national public health initiative. We recognized that to improve our screening, a one-size-fits-all approach would not work. We sought ways to use nursing and other care staff beyond physicians to improve our screening rates. The goal was to get more people screened, make the largest impact we could to detect colorectal cancer and ultimately save lives.

Actions Taken

- Offer multiple screening methods to patients
- Reduce structural barriers for patients
- Optimize EMR to include clinical team reminders and utilization of a recall system
- Implement provider assessment and feedback initiatives
- Implement FluFIT pilots
- Improve data transparency
- Collaborate across entire organization

Data

Measurement:

- MNCM specifications
- Ages 50-75 up to date with colorectal cancer screening

Methodology:

- Sanford Improvement Model
- PDSA, Report Outs
- Process/workflow mapping

Analysis

- As of February 2018, 12 of Sanford Health's primary care clinics are exceeding the 80% screening goal
- Current screening rate at 73.6%, increase of 4.9% from 2015
- Increase of over 15,000 patients receiving screenings since 2015
- Organization is the inaugural recipient of the Organization of the Year for the 2018 North Dakota Colorectal Cancer Screening Achievement Awards given by the North Dakota Colorectal Cancer Roundtable

Next Steps

- Continue to spread best practices across all clinics
- Provide focused improvement advisor support to low performing clinics
- Implement FIT mailing pilot
- Identify patients needing early screening
- Increase public awareness of colorectal cancer screenings importance

Exemplar Practice

Sanford Health
Fargo Children's Clinics

- Introduction
  - Provides care for over 25,500 patients & PCMH Certified (Patient-Centered Medical Home)
  - Active Patient and Family Advisory Council
  - Provides multi-disciplinary care
    - RN Health Coach, Social Worker, IHT, Respiratory Therapist, Panel Assistant
  - Integrated with multiple Pediatric Specialty providers
    - Cardiology, Endocrinology, General Surgery, Oncology, Rheumatology, Infectious Disease, Orthopedics
- Outstanding Achievement
  - Well Child Visits First 15 Months – NDBCBS Fargo Region Data
    - Baseline rate - 65.4%, Current Rate - 72.4%
    - Around 70% of the NDBCBS patients eligible for Well Child Infant visits are attributed to Fargo Children's Clinics
  - Asthma
    - Optimal Asthma Control: Baseline rate – 70.3%, Current Rate – 73.9%
    - Asthma Action Plan: Baseline rate – 66.2%, Current Rate – 74.1%
    - Use of Appropriate Medications for Asthma – 68% to 80% ($247,136.94 cost savings)

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SANFORD
Children's

Closing Remarks

Phase Progression Analysis

- Graduated 22 practices into an APM on January 1, 2018
  - Comprehensive Primary Care Plus (CPC+)
- Phase Breakdown after our June 2018 follow-up PAT submission:

Phase	Practice Count
Phase 1	0
Phase 2	40
Phase 3	55
Phase 4	156
Phase 5	33

Rural Challenges & Approach

- **Enderlin Clinic, ND** (population 868)
  - Expanded hours to meet the needs of the plant
- **Mountain Lake Clinic, MN** (population 2,102)
  - Mammo truck – one person fills the schedule
- **Ellendale Clinic, ND** (population 1,286)
  - Oakes Mammo truck shifted to Ellendale
- **FIT Mailing Pilot**
- **Community Fridge Partnership**

Key Takeaways

- Transforming Clinical Practice is a marathon
  - Organize, empower, and nurture your TEAM
    - Develop a strategic plan
      - Start somewhere and start small – grow from there
    - Right care, Right time, Right person
    - Educate and train your team
      - Examples: Health Maintenance Protocols, Co-visits
  - Daily huddles and regular team meetings
  - Incorporate new roles into your clinics
    - Partner with tele-services in rural settings
  - Engage and activate your patients
  - Optimize the use of your EMR
  - Use data to drive improvement
  - Celebrate with your team

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Questions??

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Moving to an ACO – Lessons Learned

Antonio Rios, M.D., FACP, CPE
Chief Physician Executive

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NGPG

- 330+ providers (220 physicians and 110 APP’s
- 26 specialties, medical and procedural, inpatient and outpatient
- Achieved MIPS score of 99.24% with an upward adjustment of 1.98% (TCPI work is paying off!)

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NGPG's Current State

- The Medicare Shared Savings Program (Shared Savings Program) facilitates coordination among providers to improve the quality of care for Medicare fee-for-service beneficiaries while reducing the growth in health care costs.
- NGPG joined in creating our local HP2 (CIN) ACO, and began participating as a group 1/1/18.
- 2018 is a reporting year. 2019 will be our first performance year.
- NGPG is currently in the process of operationalizing quality for optimal performance in 2019.

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Lessons Learned…

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Identify data needs and resources

- Find out what successful ACOs know:
  - Annual Wellness Exams
  - HCC Coding to drive better quality performance and higher savings
  - You'll need analytics of ALL the data you have

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Lessons learned…

- Look at prior MIPS performance scores to identify risk for ACO performance challenges

- Identify the ACO measures that pertain to your first year (reporting measures only) and your 2nd year (has BOTH reporting and performance measures)

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Build your data structure

- Identify reporting needs
- Robust validation of data during reporting year
- Design and test intervention plans for when metrics are heading in wrong direction

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Build your data structure

- Have a quality professional or other subject matter expert work closely with IT to ensure correct CMS numerator/denominator definitions.
- Share the measure definitions with all staff

Percentage of patients 18 to 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mmHg) during the measurement period (Jan. 1st to Dec. 31st).

Numerator Patients whose blood pressure at the most recent visit is adequately controlled (systolic < 140 mmHG and diastolic < 90 mmHG) during the calendar year.

Denominator Patients 18 – 85 years of age who had a diagnosis of essential hypertension *within the first 6 months of the calendar year or any time prior to January 1st.*

Percentage of patients aged ≥ 12 years screened for depression on the date of the encounter using an age appropriate standardized depression screening tool *AND, if positive,* a follow-up plan is documented on the date of the positive screen.

Numerator Patients screened for depression on the date of the encounter using an age appropriate standardized tool, *AND, if positive,* a follow-up plan is documented on the date of the positive screen.

Denominator All patients aged ≥ 12 years before the beginning of the measurement period (January 1st through December 31st) with at least one eligible encounter during the measurement period.

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Educate, Educate, Educate

- Assume most providers don't truly know much about Accountable Care Organizations
- ACOs are run by providers, not insurance companies
- Staff needs to be educated

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Educate: Stop the Rumors Early

- Rumor: ACOs don't improve quality.
  - Fact: ACOs outperformed published benchmarks for quality and patient experience.
- Rumor: CMS won't give money back.
  - Fact: ACOs generated over $372 million in savings while improving patient care. The ACOs qualified for $445 million in shared savings payments.

CMS quality and financial performance results, 2014

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Educate: Stop the Rumors Early

- Rumor: It's a fad, let me get back to work.
  - Fact: CMS announced that 99 more ACOs have joined the ACO Shared Savings program in 2017. 79 ACOs renewed their participation bringing the total number of Medicare Shared Savings ACOs to 572.

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Educate, Educate, Educate

- Providers need education on what impacts the outcome at the end of the year, and how shared savings are calculated
  - Is it care coordination or patient safety?
  - Is it preventive health?
  - Is it population health?
  - Is it patient experience?

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Data, and More Education

- Involve providers in identifying improvement opportunities
- Empower quality and operations leaders to intervene when metrics are moving in the wrong direction (IT or process flow)
- Re-educate and coach staff to standard work
- Assist in IT prioritization
- Revise standard work as necessary

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Data, and More Education

- Be transparent in sharing patient experience data
- Let providers learn from each other best practices
  - Collaboratives
  - PODS (by region or specialty)
  - “Encourage” participation via Q&C bonuses