Utilization and Choosing Wisely

Tom Evans, MD

TCPi 2018 Learning Community
Delivery System Reform Requires Focus

Provider Payment

Care Delivery

Information Distribution

HELP!!
TCPi: 5 Phases of Transformation

- Set Aims
- Use Data to Drive Care
- Achieve Progress on Aims
- Achieve Benchmark Status
- Thrive as a Business via Pay for Value Approaches

TCPi 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
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
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
• 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”
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
Some Examples of CW Recommendations

- Society of General Internal Medicine (5)
- American Academy of Family Physicians (15)
- American Academy of Pediatrics (10)
• **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
• **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
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)
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.
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
Transforming Clinical Practice
The State of the Union

Tom Evans, MD
Compass PTN Learning Community
Summer 2018
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

Healthier People

Better Care

Smarter Spending

The Triple Aim

National → State → Community
Pay Providers
deliver care
distribute information

Delivery System Reform Requires Focus
MACRA: QPP
Quality Payment Program

1. Merit-based Incentive Payment System (MIPS)
2. Alternative Payment Models (APM)
3. 
4. 

Diagram with a ladder:
- Step 1: Merit-based Incentive Payment System (MIPS)
- Step 2: Alternative Payment Models (APM)
- Steps 3 and 4 are not labeled in the diagram.
TCPI: 5 Phases of Transformation

- **Set Aims**
- **Use Data to Drive Care**
- **Achieve Progress on Aims**
- **Achieve Benchmark Status**
- **Thrive as a Business via Pay for Value Approaches**

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Health Care and GDP
Medicare spending is a growing share of the federal budget

- Medicare
- Medicaid
- Social Security
- Other Programs
- Net Interest

1970: 73%
2014: 46%
2040: 24%

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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2. Alternative Payment Models (APM)
3. 
4. 
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PTNs Determine Exemplars

PTN Enrolled Practices

Phase 2, 3

Phase 4, 5

Not Yet Exemplary

Exemplary
PTNs Determine Exemplars

- Enrolled Practices
  - Phase 2, 3
  - Phase 4, 5

PTN Formal Process To Assess, Verify Exemplars

- Not Yet Exemplary
- Exemplary
Identified Exemplary Practices

Celebrating a Significant Milestone

2015  Aug 2018  Dec 2019

Exemplary Practices

1,000
Achieving 10,000 Exemplary Practices

Creating to Exponential Growth

Celebrating a Significant Milestone

Exemplary Practices

2015

Aug 2018

Dec 2019

1,000

10,000!
PTNs Determine Exemplars

PTN Formal Process To Assess, Verify Exemplars

Enrolled Practices
- Phase 2, 3
- Phase 4, 5

Not Yet Exemplary
Exemplary

Payers (ACOs)

PTN National Exemplary Practice Registry
PTNs Market Exemplars

- Enrolled Practices
  - Phase 2, 3
  - Phase 4, 5

- PTN Formal Process To Assess, Verify Exemplars

- Payers (ACOs)

- PTN National Exemplary Practice Registry

- Not Yet Exemplary
- Exemplary
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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
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…
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
Documentation Pearls for Surviving Payment for Performance

surviving value based medicine

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

e-mail: steve.adams@inhealthps.com
web: thecodingeducator.com
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)
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
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
Cost Measures
- Submitted via Administrative Claims in PY18
- Improvement Activities
  - Attestation for at least 90 Days
- Promoting Interoperability
  - Attestation for at least 90 Days

Quality
- Data for 12 Months
  - 50%
  - 25%
  - 15%
  - 10%
2018 MIPS Quality

Patient Name: ___________________________ DOS: ________________

Do this on every Red White and Blue Medicare Patient

<table>
<thead>
<tr>
<th># 1 DESCRIPTION: Hemoglobin A1c Management (only if the patient has type 1 or 2 DM)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator Options (Pick One):</td>
</tr>
<tr>
<td>[ ] Most recent hemoglobin A1c (HbA1c) level less than 7.0% (3044F)</td>
</tr>
<tr>
<td>OR</td>
</tr>
<tr>
<td>[ ] Most recent hemoglobin A1c (HbA1c) level between 7.0 to 9.0% (3045F)</td>
</tr>
<tr>
<td>OR</td>
</tr>
<tr>
<td>[ ] Most recent hemoglobin A1c level over 9.0% (3046F)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th># 110 DESCRIPTION: Current Season’s Influenza Immunization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator Options (Pick One) During October 1, 2018 and December 31, 2018</td>
</tr>
<tr>
<td>[ ] Yes, the patient got a flu shot this year (G8482)</td>
</tr>
<tr>
<td>OR</td>
</tr>
<tr>
<td>[ ] Nope, there is a medical reason for not giving flu shot or the patient refused (G8483)</td>
</tr>
<tr>
<td>OR</td>
</tr>
<tr>
<td>[ ] Nope, this person has not had a flu shot this year (G8484)</td>
</tr>
<tr>
<td>Type</td>
</tr>
<tr>
<td>-----------------------------------</td>
</tr>
<tr>
<td>Procedural</td>
</tr>
<tr>
<td>Procedural</td>
</tr>
<tr>
<td>Procedural</td>
</tr>
<tr>
<td>Procedural</td>
</tr>
<tr>
<td>Procedural</td>
</tr>
<tr>
<td>Acute IP Medical Condition</td>
</tr>
<tr>
<td>Acute IP Medical Condition</td>
</tr>
<tr>
<td>Acute IP Medical Condition</td>
</tr>
</tbody>
</table>
### Appendix B: Episode-Level Table for All Episodes Attributed to You

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

<table>
<thead>
<tr>
<th>Episode Group</th>
<th>Episode ID</th>
<th>Episode Sub-Group (if applicable)</th>
<th>Observed (Non-Risk-Adjusted Cost)</th>
<th>Risk-Adjusted Cost</th>
<th>Risk-Adjusted Cost Percentile</th>
<th>Risk Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening/Surveillance Colonoscopy</td>
<td>24545.6992</td>
<td>-</td>
<td>$1,352</td>
<td>$1,334</td>
<td>93rd</td>
<td>1.01</td>
</tr>
<tr>
<td>Screening/Surveillance Colonoscopy</td>
<td>24624.6022</td>
<td>-</td>
<td>$1,467</td>
<td>$1,401</td>
<td>94th</td>
<td>1.05</td>
</tr>
<tr>
<td>Screening/Surveillance Colonoscopy</td>
<td>24774.0702</td>
<td>-</td>
<td>$851</td>
<td>$809</td>
<td>43rd</td>
<td>1.05</td>
</tr>
<tr>
<td>Screening/Surveillance Colonoscopy</td>
<td>24819.6682</td>
<td>-</td>
<td>$1,389</td>
<td>$1,382</td>
<td>94th</td>
<td>1.00</td>
</tr>
<tr>
<td>Screening/Surveillance Colonoscopy</td>
<td>24892.1002</td>
<td>-</td>
<td>$1,131</td>
<td>$1,126</td>
<td>82nd</td>
<td>1.00</td>
</tr>
<tr>
<td>Screening/Surveillance Colonoscopy</td>
<td>25157.6202</td>
<td>-</td>
<td>$937</td>
<td>$951</td>
<td>60th</td>
<td>0.98</td>
</tr>
<tr>
<td>Screening/Surveillance Colonoscopy</td>
<td>25204.6802</td>
<td>-</td>
<td>$526</td>
<td>$514</td>
<td>3rd</td>
<td>1.04</td>
</tr>
<tr>
<td>Screening/Surveillance Colonoscopy</td>
<td>25389.0452</td>
<td>-</td>
<td>$197</td>
<td>$190</td>
<td>0th</td>
<td>1.03</td>
</tr>
<tr>
<td>Screening/Surveillance Colonoscopy</td>
<td>25625.0132</td>
<td>-</td>
<td>$1,150</td>
<td>$779</td>
<td>39th</td>
<td>1.48</td>
</tr>
<tr>
<td>Screening/Surveillance Colonoscopy</td>
<td>25638.0092</td>
<td>-</td>
<td>$521</td>
<td>$499</td>
<td>8th</td>
<td>1.04</td>
</tr>
</tbody>
</table>
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.
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.
### Shared Savings Program ACO Participation Options

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

<table>
<thead>
<tr>
<th>Track</th>
<th>Financial Risk Arrangement</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>One-sided</td>
<td>Track 1 ACOs do not assume downside risk (shared losses) if they do not lower growth in Medicare expenditures.</td>
</tr>
<tr>
<td>Medicare ACO Track 1+ Model*</td>
<td>Two-sided</td>
<td>Medicare ACO Track 1+ Model (Track 1+ Model) ACOs assume limited downside risk (less than Track 2 or Track 3).</td>
</tr>
<tr>
<td>2</td>
<td>Two-sided</td>
<td>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.</td>
</tr>
<tr>
<td>3</td>
<td>Two-sided</td>
<td>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.</td>
</tr>
</tbody>
</table>
# 2018 Accountable Care Organization Information

## ACO Characteristics

<table>
<thead>
<tr>
<th>ACO Characteristics</th>
<th>ACOs</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Risk Based:</td>
<td>460</td>
<td>82%</td>
</tr>
<tr>
<td>Track 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk Based:</td>
<td>55</td>
<td>10%</td>
</tr>
<tr>
<td>Track 1+ Model</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SNF 3-Day Rule Waiver</td>
<td>31</td>
<td>–</td>
</tr>
<tr>
<td>Track 2</td>
<td>8</td>
<td>1%</td>
</tr>
<tr>
<td>Track 3</td>
<td>38</td>
<td>7%</td>
</tr>
<tr>
<td>SNF 3-Day Rule Waiver</td>
<td>30</td>
<td>–</td>
</tr>
</tbody>
</table>

## ACO Composition

<table>
<thead>
<tr>
<th>ACO Composition</th>
<th>ACOs</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians Only</td>
<td>171</td>
<td>30%</td>
</tr>
<tr>
<td>Physicians, Hospitals, &amp; Other Facilities</td>
<td>324</td>
<td>58%</td>
</tr>
<tr>
<td>FQHCs / RHCs</td>
<td>66</td>
<td>12%</td>
</tr>
</tbody>
</table>

## ACO Participant List Composition

<table>
<thead>
<tr>
<th>ACOs</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant TINs</td>
<td>20,690</td>
</tr>
<tr>
<td>Physicians, PAs, NPs, CNSs</td>
<td>377,515</td>
</tr>
<tr>
<td>Hospitals</td>
<td>1,517</td>
</tr>
<tr>
<td>Federally Qualified Health Centers</td>
<td>2,560</td>
</tr>
<tr>
<td>Rural Health Centers</td>
<td>1,210</td>
</tr>
<tr>
<td>Critical Access Hospitals</td>
<td>421</td>
</tr>
</tbody>
</table>

## 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

<table>
<thead>
<tr>
<th>Measure ID</th>
<th>Measure Name</th>
<th>Denominator</th>
<th>Numerator</th>
<th>NOS Domain</th>
<th>Measure Type/QPP Priority Level</th>
<th>QPP Specialty Measure Set</th>
</tr>
</thead>
<tbody>
<tr>
<td>NEW MEASURE eMeasure ID: N/A eMeasure NOF: N/A NOF: N/A QualityID: 402</td>
<td>Tobacco Use and Help with Quitting Among Adolescents</td>
<td>All patients aged 12-20 years with a visit during the measurement period</td>
<td>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</td>
<td>Community/Population Health</td>
<td>Process</td>
<td>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</td>
</tr>
<tr>
<td>NEW MEASURE eMeasure ID: CMSv6 eMeasure NOF: N/A NOF: 0418 QualityID: 134</td>
<td>Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan</td>
<td>All patients aged 12 years and older</td>
<td>Patients screened for depression on the date of the encounter using an age appropriate standardized tool AMD, if positive, a follow-up plan is documented on the date of the positive screen</td>
<td>Community/Population Health</td>
<td>Process</td>
<td>Internal Medicine Mental/Behavioral Health General Practice Family Medicine Pediatrics</td>
</tr>
</tbody>
</table>
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
Annual Depression Screen

The HCPCS Code

**G0444** - Annual Depression Screening – 15 minutes

ICD-10: **Z13.89**

**Frequency**: Annually

**MCR Reimbursement**: $17.13
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

INHALE 2 PUFFS BY MOUTH EVERY 4 HOURS RECTALLY

VENTOLIN HFA 90 MCG INHALER

DOSAGE Counter 200 INH
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.
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.
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
<table>
<thead>
<tr>
<th>Clinical Episode</th>
<th>Matched EIs (#)</th>
<th>Matched Intervention Period Episodes (#)</th>
<th>Average Length of Participation (Quarters)</th>
<th>Els that Terminated Participation in the Clinical Episode (%)</th>
<th>Episodes from Els that Terminated (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute myocardial infarction</td>
<td>93</td>
<td>5,337</td>
<td>5</td>
<td>41%</td>
<td>36%</td>
</tr>
<tr>
<td>Cardiac arrhythmia</td>
<td>70</td>
<td>6,029</td>
<td>5</td>
<td>51%</td>
<td>45%</td>
</tr>
<tr>
<td>Cardiac valve</td>
<td>31</td>
<td>3,957</td>
<td>6</td>
<td>48%</td>
<td>53%</td>
</tr>
<tr>
<td>Cellulitis</td>
<td>79</td>
<td>5,174</td>
<td>5</td>
<td>43%</td>
<td>50%</td>
</tr>
<tr>
<td>Cervical spinal fusion</td>
<td>34</td>
<td>1,190</td>
<td>5</td>
<td>44%</td>
<td>34%</td>
</tr>
<tr>
<td>Congestive heart failure</td>
<td>173</td>
<td>31,858</td>
<td>5</td>
<td>30%</td>
<td>29%</td>
</tr>
<tr>
<td>COPD, bronchitis, asthma</td>
<td>133</td>
<td>18,331</td>
<td>6</td>
<td>31%</td>
<td>33%</td>
</tr>
<tr>
<td>Coronary artery bypass graft</td>
<td>43</td>
<td>3,242</td>
<td>6</td>
<td>28%</td>
<td>32%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>45</td>
<td>1,123</td>
<td>5</td>
<td>38%</td>
<td>24%</td>
</tr>
<tr>
<td>Esophagitis, gastroenteritis &amp; other digestive disorders</td>
<td>58</td>
<td>4,104</td>
<td>4</td>
<td>53%</td>
<td>48%</td>
</tr>
<tr>
<td>Fractures of the femur and hip or pelvis</td>
<td>47</td>
<td>1,092</td>
<td>5</td>
<td>34%</td>
<td>36%</td>
</tr>
<tr>
<td>Gastrointestinal hemorrhage</td>
<td>58</td>
<td>4,386</td>
<td>4</td>
<td>66%</td>
<td>51%</td>
</tr>
<tr>
<td>Gastrointestinal obstruction</td>
<td>51</td>
<td>1,735</td>
<td>4</td>
<td>53%</td>
<td>47%</td>
</tr>
<tr>
<td>Hip &amp; femur procedures except major joint</td>
<td>101</td>
<td>7,446</td>
<td>5</td>
<td>36%</td>
<td>26%</td>
</tr>
<tr>
<td>Lower extremity and humerus procedure except hip, foot, femur</td>
<td>37</td>
<td>1,089</td>
<td>6</td>
<td>38%</td>
<td>28%</td>
</tr>
<tr>
<td>Major bowel procedure</td>
<td>46</td>
<td>3,029</td>
<td>5</td>
<td>39%</td>
<td>37%</td>
</tr>
<tr>
<td>Major joint replacement of the lower extremity</td>
<td>303</td>
<td>97,922</td>
<td>6</td>
<td>19%</td>
<td>14%</td>
</tr>
<tr>
<td>Major joint replacement of the upper extremity</td>
<td>26</td>
<td>1,337</td>
<td>5</td>
<td>31%</td>
<td>21%</td>
</tr>
<tr>
<td>Medical non-infectious orthopedic</td>
<td>94</td>
<td>6,588</td>
<td>5</td>
<td>43%</td>
<td>35%</td>
</tr>
<tr>
<td>Nutritional and metabolic disorders</td>
<td>57</td>
<td>2,727</td>
<td>4</td>
<td>47%</td>
<td>51%</td>
</tr>
<tr>
<td>Other respiratory</td>
<td>62</td>
<td>4,700</td>
<td>5</td>
<td>42%</td>
<td>32%</td>
</tr>
<tr>
<td>Other vascular surgery</td>
<td>36</td>
<td>1,590</td>
<td>5</td>
<td>44%</td>
<td>38%</td>
</tr>
<tr>
<td>Percutaneous coronary intervention</td>
<td>45</td>
<td>4,745</td>
<td>5</td>
<td>24%</td>
<td>23%</td>
</tr>
</tbody>
</table>
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
This allows insurance companies an opportunity to forecast future expenditures on each patient within the risk model.
Medicare - CCW Condition Period Prevalence, 2013

- Acute Myocardial Infarction: 15%
- Alzheimer's: 1%
- Aneurysm: 5%
- Asthma: 11%
- Atrial Fibrillation: 23%
- Benign Prostatic Hyperplasia: 5%
- Chronic Kidney Disease: 8%
- Colorectal Cancer: 14%
- Depression: 18%
- Diabetes: 17%
- Endometrial Cancer: 12%
- Heart Failure: 28%
- Hepatitis C: 5%
- Hypercholesterolemia: 15%
- Hypertension: 47%
- Ischemic Heart Disease: 57%
- Lung Cancer: 29%
- Osteoporosis: 6%
- Prostate Cancer: 7%
- Rheumatoid Arthritis/Osteoarthritis: 30%
- Stroke: 4%
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
Add Up the total RAF score at the end of the year for a patient (don’t double dip)

Multiply by the conversion factor

\[ .4 \times 9,000 = 3,600 \]
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
Goal

1.0 - 2.0
<table>
<thead>
<tr>
<th>RAF</th>
<th>HCC</th>
<th>DX</th>
<th>Hypertension</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>NA</td>
<td>l10</td>
<td>Essential (primary) hypertension, stable</td>
</tr>
</tbody>
</table>
| 0.345 | 85  | l110| Hypertensive heart disease with heart failure  
   *Use additional code for heart failure*                                                          |
| 0   | NA  | l119| Hypertensive heart disease without heart failure                                                                                          |
| 0.288 | 136 | l120| Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease  
   *Use additional code for CKD*                                                                   |
| 0   | NA  | l129| Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease  
   *Use additional code for CKD*                                                                   |
| 0   | NA  | l130| 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  | l1310| 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 | l1311| 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 | l132| 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*                                                                   |
<table>
<thead>
<tr>
<th>RAF</th>
<th>HCC</th>
<th>DX</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.105</td>
<td>19</td>
<td>E119</td>
<td>Type 2 diabetes mellitus without complications</td>
</tr>
<tr>
<td>0.305</td>
<td>18</td>
<td>E1121</td>
<td>with diabetic nephropathy</td>
</tr>
<tr>
<td>0.305</td>
<td>18</td>
<td>E1122</td>
<td>with diabetic chronic kidney disease</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><em>Use additional code for CKD</em></td>
</tr>
<tr>
<td>0.305</td>
<td>18</td>
<td>E1129</td>
<td>with other diabetic kidney complication</td>
</tr>
<tr>
<td>0.305</td>
<td>18</td>
<td>E1140</td>
<td>with diabetic neuropathy, unspecified</td>
</tr>
<tr>
<td>0.305</td>
<td>18</td>
<td>E1141</td>
<td>with diabetic mononeuropathy</td>
</tr>
<tr>
<td>0.305</td>
<td>18</td>
<td>E1142</td>
<td>with diabetic polyneuropathy</td>
</tr>
<tr>
<td>0.305</td>
<td>18</td>
<td>E1143</td>
<td>with diabetic autonomic (poly)neuropathy</td>
</tr>
<tr>
<td>0.305</td>
<td>18</td>
<td>E1149</td>
<td>with other diabetic neurological complication</td>
</tr>
<tr>
<td>0.305</td>
<td>18</td>
<td>E1151</td>
<td>with diabetic peripheral angiopathy without gangrene</td>
</tr>
<tr>
<td>0.305</td>
<td>18</td>
<td>E1152</td>
<td>with diabetic peripheral angiopathy with gangrene</td>
</tr>
<tr>
<td>0.305</td>
<td>18</td>
<td>E1159</td>
<td>with other circulatory complications</td>
</tr>
<tr>
<td>0.305</td>
<td>18</td>
<td>E11610</td>
<td>with diabetic neuropathic arthropathy</td>
</tr>
<tr>
<td>0.305</td>
<td>18</td>
<td>E11620</td>
<td>with diabetic dermatitis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>E11621</td>
<td>with foot ulcer</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><em>Use additional code for foot ulcer - L97 series</em></td>
</tr>
<tr>
<td>0.305</td>
<td>18</td>
<td>E11622</td>
<td>with other skin ulcer</td>
</tr>
<tr>
<td>0.305</td>
<td>18</td>
<td>E11628</td>
<td>with other skin complications</td>
</tr>
<tr>
<td>0.305</td>
<td>18</td>
<td>E11630</td>
<td>with periodontal disease</td>
</tr>
<tr>
<td>0.305</td>
<td>18</td>
<td>E11638</td>
<td>with other oral complications</td>
</tr>
<tr>
<td>0.305</td>
<td>18</td>
<td>E11649</td>
<td>with hypoglycemia without coma</td>
</tr>
<tr>
<td>0.305</td>
<td>18</td>
<td>E1165</td>
<td>with hyperglycemia</td>
</tr>
<tr>
<td>0.305</td>
<td>18</td>
<td>E1169</td>
<td>with other specified complication</td>
</tr>
<tr>
<td>0.105</td>
<td>19</td>
<td>Z794</td>
<td>Long term (current) use of insulin</td>
</tr>
<tr>
<td>RAF</td>
<td>HCC</td>
<td>DX</td>
<td>CHRONIC KIDNEY DISEASE</td>
</tr>
<tr>
<td>-----</td>
<td>-----</td>
<td>-----</td>
<td>------------------------</td>
</tr>
<tr>
<td>0</td>
<td>NA</td>
<td>N181</td>
<td>Stage 1, CKD</td>
</tr>
<tr>
<td>0</td>
<td>NA</td>
<td>N182</td>
<td>Stage 2, CKD</td>
</tr>
<tr>
<td>0</td>
<td>NA</td>
<td>N183</td>
<td>Stage 3, CKD</td>
</tr>
<tr>
<td>0.288</td>
<td>137</td>
<td>N184</td>
<td>Stage 4, CKD</td>
</tr>
<tr>
<td>0.288</td>
<td>136</td>
<td>N185</td>
<td>Stage 5, CKD</td>
</tr>
<tr>
<td>0.288</td>
<td>136</td>
<td>N186</td>
<td>Stage 6, CKD</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RAF</th>
<th>HCC</th>
<th>DX</th>
<th>DIALYSIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.456</td>
<td>134</td>
<td>Z992</td>
<td>Dependence on renal dialysis</td>
</tr>
<tr>
<td>0.456</td>
<td>134</td>
<td>Z9115</td>
<td>Patient's noncompliance with renal dialysis</td>
</tr>
</tbody>
</table>
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>
<thead>
<tr>
<th>Diagnosis</th>
<th>Diagnosis ICD-10</th>
<th>HCC</th>
<th>RAF</th>
<th>Projected Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>I10</td>
<td>NA</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>DM, Controlled</td>
<td>E11.9</td>
<td>19</td>
<td>0.105</td>
<td>$983.57</td>
</tr>
<tr>
<td>Future Expenditures</td>
<td></td>
<td></td>
<td>0.105</td>
<td>$983.57</td>
</tr>
</tbody>
</table>
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>
<thead>
<tr>
<th>Diagnosis</th>
<th>Diagnosis ICD-10</th>
<th>HCC</th>
<th>RAF</th>
<th>Projected Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension with Stage 4 CKD</td>
<td>I12.9</td>
<td>NA</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Stage 4 CKD</td>
<td>N18.4</td>
<td>137</td>
<td>.288</td>
<td></td>
</tr>
<tr>
<td>Uncontrolled DM</td>
<td>E11.65</td>
<td>18</td>
<td>.305</td>
<td></td>
</tr>
<tr>
<td>Alcohol Dependence in Remission</td>
<td>F10.21</td>
<td>55</td>
<td>.344</td>
<td></td>
</tr>
<tr>
<td>Long Term Use of Insulin</td>
<td>Z79.4</td>
<td>19</td>
<td>.105</td>
<td>Can’t bill a 19 and 18 together</td>
</tr>
<tr>
<td>Acquired Absence of Great Toe</td>
<td>Z89.412</td>
<td>189</td>
<td>.521</td>
<td></td>
</tr>
<tr>
<td>BMI of 40</td>
<td>Z68.41</td>
<td>22</td>
<td>.244</td>
<td></td>
</tr>
<tr>
<td>Future Expenditures</td>
<td></td>
<td>1.702</td>
<td>$15,943.21</td>
<td></td>
</tr>
</tbody>
</table>
Final Thoughts I Share With My Clients

MATH MADE SIMPLE.

IF YOU HAVE $20 AND YOUR WIFE HAS $5, SHE HAS $25.
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)
Questions?
Any Questions

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Web: www.thecodingeducator.com
Twitter: @thekingofcoders
Instagram: kingofcoders
Facebook: facebook.com/kingofcoders
SANFORD HEALTH
Transforming Clinical Practice Initiative (TCPI)

Georgia Learning Community
Tessi Ross, BSN, MPA, RN, CPHQ
August 11, 2018
“The project described was supported by Funding Opportunity Number CMS-1L1-15-003 from the U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. The contents provided are solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies.”
Introduction to Sanford Health

COMPASS PTN partner organization
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**

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**
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
- Jennifer Weiss, BS, Sioux Falls Region
- Kate Syverson, MSW, LICSW, CPHQ, Fargo Region
- Laura Scott, MBA, Fargo Region
- Kathy Bacon, Program Coordination, Enterprise Clinic Services
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
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

**Patient & Family-Centered Care**
- 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
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
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

Sanford Journey:
- 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
- Lessons learned: Start small, then spread; Start with one change
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
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.
1) Understand the Why
2) Measurement Overview
3) Diagnostic Precision
4) Improvement Strategies
5) Clinical Practice Guidelines
6) Patient Engagement
7) Cross-Cultural Considerations
## Results

Enterprise Rates Improved for both measures:

<table>
<thead>
<tr>
<th></th>
<th>Jun-16</th>
<th>Jun-17</th>
<th>June-18</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>6 Month Remission</strong></td>
<td>8.02%</td>
<td>10.80%</td>
<td>11.3%</td>
</tr>
<tr>
<td><strong>12 Month Remission</strong></td>
<td>N/A</td>
<td>7.45%</td>
<td>10.2%</td>
</tr>
</tbody>
</table>

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*
WE’VE GOT YOUR BACK SIDE

Sanford Health, B5, Improvement Advisor; Sanford Health; Tessa Ross, BSN, MPA, RN, CPHQ, Senior Quality Strategist, 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

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

Data

**Measurement:**
- MNCH specifications
- Ages 50-75 up to date with colorectal cancer screening

**Methodology:**
- Sanford Improvement Model
- PDSA, Report Outs
- Process/workflow mapping
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)
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:

<table>
<thead>
<tr>
<th>Phase</th>
<th>Practice Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase 1</td>
<td>0</td>
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<tr>
<td>Phase 2</td>
<td>40</td>
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<tr>
<td>Phase 3</td>
<td>55</td>
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<tr>
<td>Phase 4</td>
<td>156</td>
</tr>
<tr>
<td>Phase 5</td>
<td>33</td>
</tr>
</tbody>
</table>
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
Questions??
Moving to an ACO – Lessons Learned

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

Improving the health of our community in all we do.
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!)
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.
Lessons Learned...
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
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)
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
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

### 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.

### Numerator
- 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.

### 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.
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
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.
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.
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?

Yes, to all of these 4 ‘domains.’
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
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