NEW JERSEY HEALTH CARE QUALITY INSTITUTE

Quality powered.

Garden Practice Transformation Network

Practice Transformation Advisors

Organized, Evidence-Based Care

Mike Renzi, DO, FACP

Continuum Health Alliance, LLC

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March 13, 2017

Notice of Disclosure:

Disclosure information: HRET, planners and the following speakers have disclosed they have no relevant financial interest or relationship with any manufacturer(s) or any commercial product(s) discussed in this educational activity. The following have provided disclosures: ***Aline Holmes, DNP, MSN, RN; Nancy Winter, MSN, RN, Thomas R. Ortiz, MD, FAAFP, Tyla Housman, Michael Renzi, DO, FACP; and HRET Planners.***

Introducing…

Mike Renzi, *Chief Medical Officer*

As Chief Medical Officer for Continuum Health Alliance, Dr. Renzi constructs, implements, and oversees the company's Population Health Management Service, including programs involving patient-centered medical care, healthcare information technology and shared savings reimbursement models.

About Continuum

Continuum Health Alliance is a physician enablement company that optimizes value-based commerce through population health, practice transformation, applied analytics and network development services. The company offers proven, strategic business and clinical solutions empowering ambulatory and community-based enterprises and other providers to enhance patient access and experience, improve health and lower overall costs. Continuum serves 1,500+ primary care physicians, specialists and nurse practitioners caring for hundreds of thousands of patients across the country.

Learn more at www.challc.net.

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Agenda

- Understanding the quality payment progression
- Defining evidence-based medicine
- Recommended steps for employing evidence-based care:
  - Defining quality metrics
  - Defining workflows
  - Reducing unnecessary testing
- Questions & Discussion

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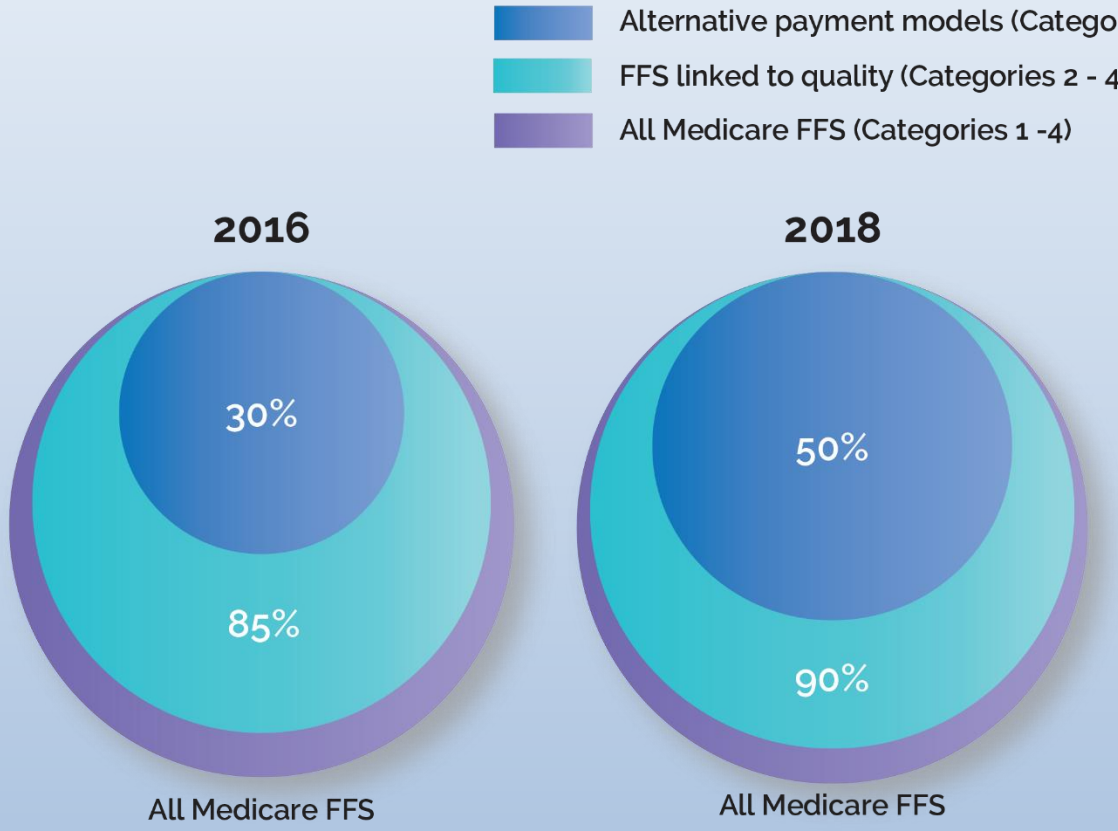
Quality Payment Progression

Target Percentage of Medicare FFS Payments Linked to Quality and Alternative Payment Models



Payment Categories

Category 1:	FFS with no link to quality
Category 2:	FFS linked to quality
Category 3:	Alternative payment models built on FFS architecture (upside or low-sided risk)
Category 4:	Population-based payment

Source: *http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26-3.html*

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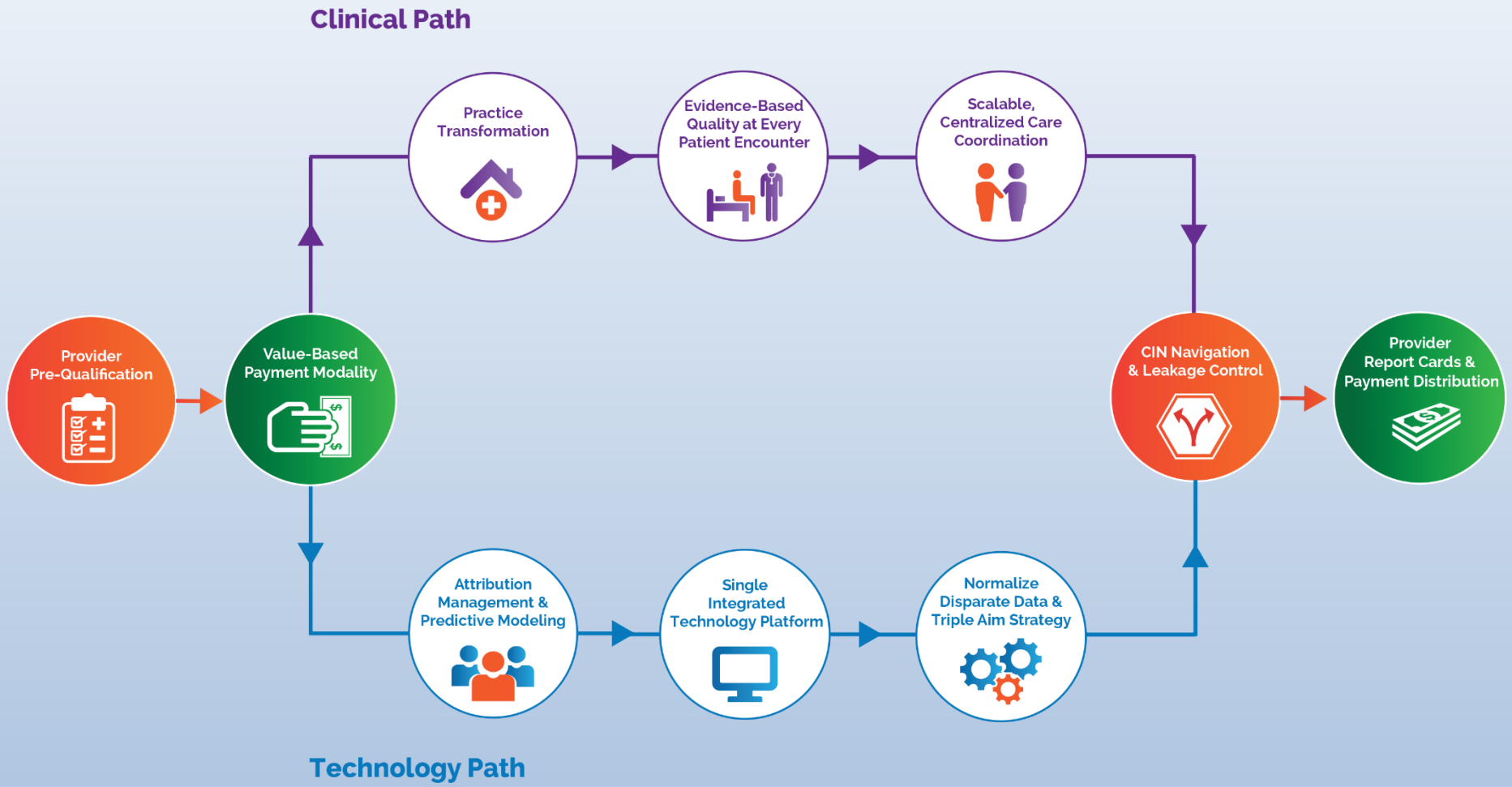
Clinical and Technological Path to Risk



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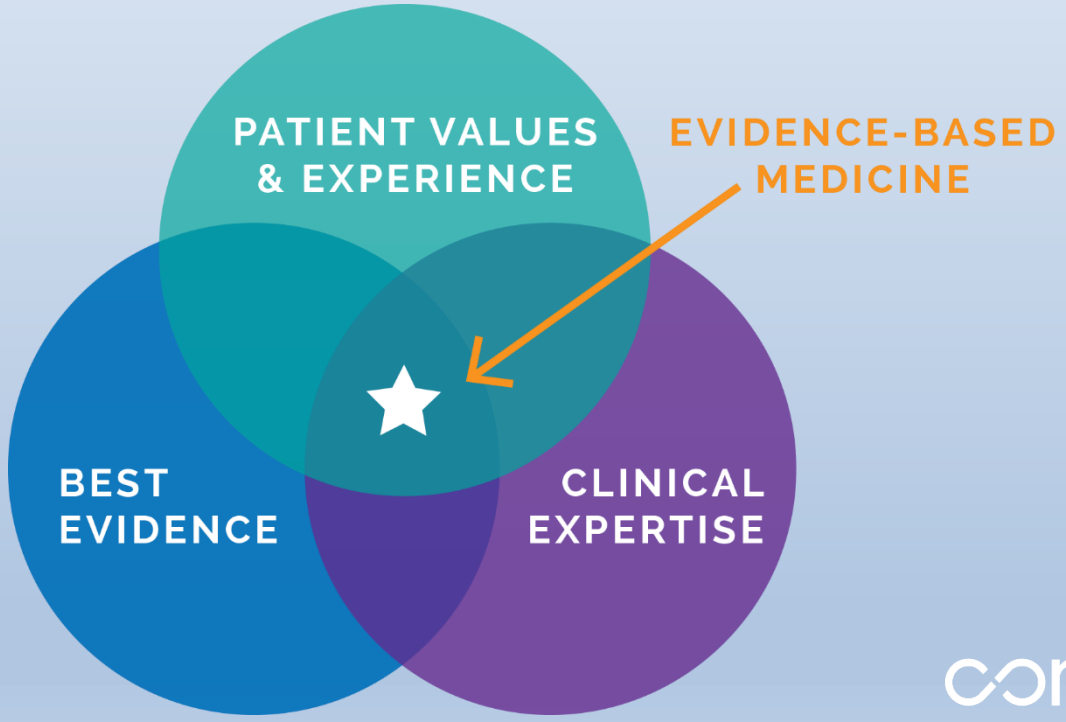
What is evidence-based medicine?

- **Definition**: Using scientific evidence in decision-making to achieve the best possible outcomes
- Originally defined in 1996 as the "conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients."
- Includes three components:



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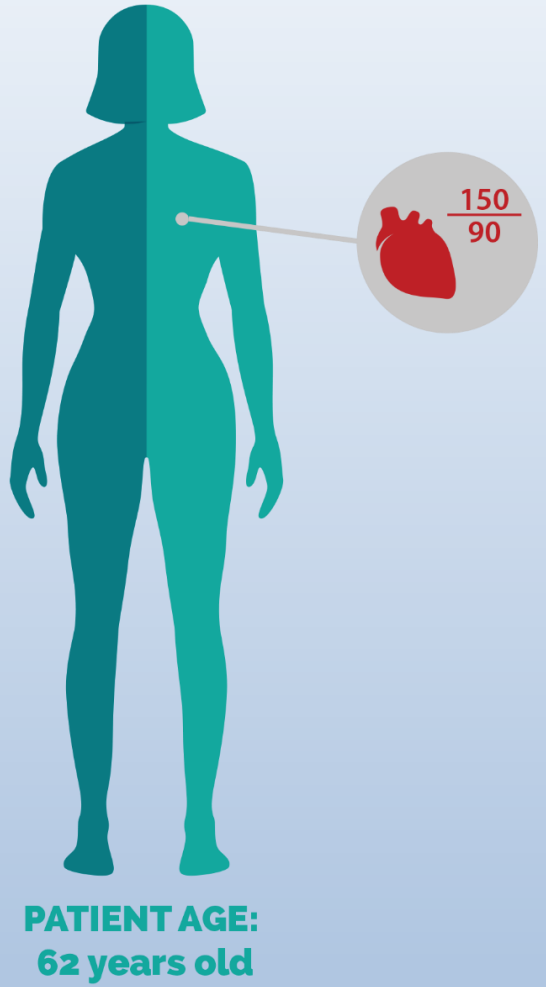
What is evidence-based medicine? (continued)

- Example: 2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults (JNC 8)
  - An evidence-based guideline outlining nine specific recommendations for initiating and modifying pharmacotherapy for patients with elevated blood pressure (BP).
  - Among those recommendations is one stating that, in general, patients 60 and older should start treatment to lower BP at a systolic blood pressure of 150 mmHg or higher or a diastolic blood pressure of 90 mmHg or higher and treat to below those thresholds.
  - The guideline also outlines which medications are best for specific patient populations based on factors such as age, race and health status.
  - This guideline simplifies the management of high blood pressure.



Source: AAFP, http://www.aafp.org/news/health-of-the-public/20131218hypertensiongdln.html

Who establishes evidence-based guidelines?

- Evidence-based research provides the basis for sound clinical practice guidelines and recommendations
  - **U.S. Preventive Services Task Force (USPSTF)** – an independent group of experts in prevention and evidence-based medicine that work to improve the health of all Americans by making evidence-based recommendations about clinical preventive services such as screenings, counseling services, or preventive medications.
  - **Healthcare Effectiveness Data and Information Set (HEDIS)** –90% of insurers use HEDIS to measure the effectiveness of care and service rendered to beneficiaries.

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Step 1: Define the Quality Process

- **Sources**:
  - Payer Programs
  - Internal Medical Home Improvement Projects
  - Medical Literature

- **Measurement**:
  - *Denominator*: Does the practice patient workflow ensure that all patients eligible for a service get offered the service?
  - *Numerator*: How often was the service performed to an acceptable standard?

- **Reporting**:
  - How/where will the outcome get recorded?
  - How will the practice monitor its population performance?
  - How will the practice report it to payers and its own providers?

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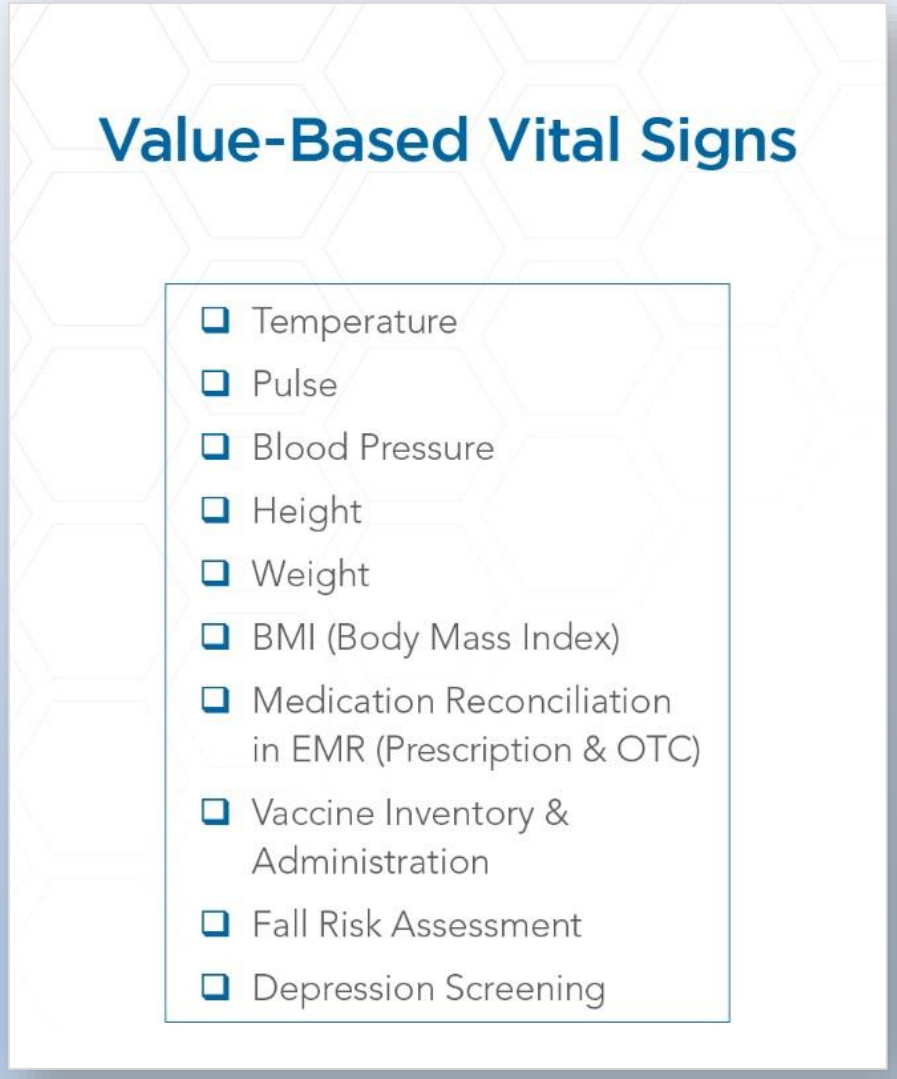
Step 2: Define Workflows/Assign Responsibility

- Who is responsible for recording the metric?
- Who is responsible for closing the gap?
- Ensure staff is working at the "top of their capabilities"

METRICS & RESPONSIBLITIES (SAMPLE)	
METRIC DESCRIPTION	RESPONSIBLE ROLE(S)
Preventive Health	
Influenza Immunization	Nurse or MA
BMI Screening and Follow-Up	Nurse measures BMI; Provider documents follow-up
Colorectal Cancer Screening	LCD
At-Risk Population	
Diabetes: Hemoglobin A1c Poor Control	LCD confirms labwork was completed; MA confirms result; Provider manages control
Hypertension: Controlling High Blood Pressure	Nurse measures blood pressure; Provider documents follow-up; LCD 360
IVD: Use of Aspirin or Another Antithrombotic	Nurse performs medication reconciliation; Provider confirms use of antiplatelet drug
Depression Remission at 12 Months	Nurse conducts screening; Provider documents follow-up; LCD manages scheduling

Example: Value-Based Vital Signs Card



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Example: Standing Orders

- Standing orders and protocols allow patient care to be shared among non-provider members of the care team, like medical assistants and nurses.
- Standing orders are often based on national clinical guidelines, but practices may customize those guidelines based on their own patient population/care environment.

- Standing orders enable all members of the care team to function to their fullest capacity ("top of capabilities")
- Other staff should also learn about the standing orders so that they can support the new roles. For example, front desk staff may schedule new kinds of appointments.

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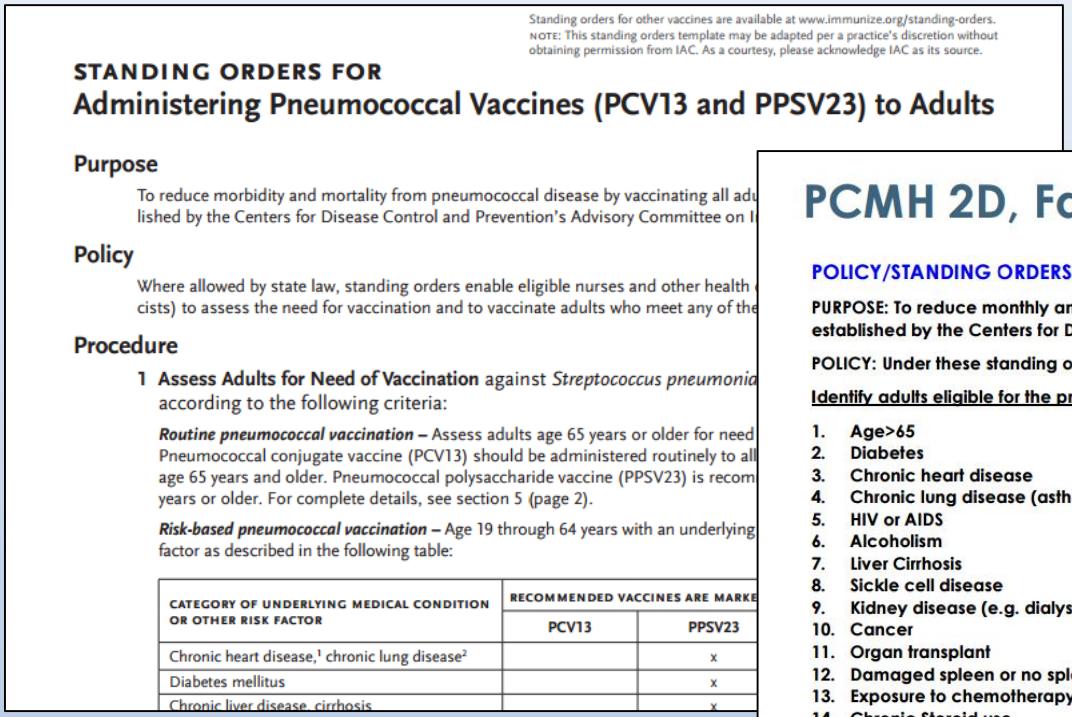
Example: Standing Orders (continued)

Pneumonia Vaccine



Standing orders for other vaccines are available at www.immunize.org/standing-orders.
NOTE: This standing orders template may be adapted per a practice's discretion without obtaining permission from IAC. As a courtesy, please acknowledge IAC as its source.

STANDING ORDERS FOR
Administering Pneumococcal Vaccines (PCV13 and PPSV23) to Adults

Purpose

To reduce morbidity and mortality from pneumococcal disease by vaccinating all adu
lished by the Centers for Disease Control and Prevention's Advisory Committee on I

Policy

Where allowed by state law, standing orders enable eligible nurses and other health
cists) to assess the need for vaccination and to vaccinate adults who meet any of the

Procedure

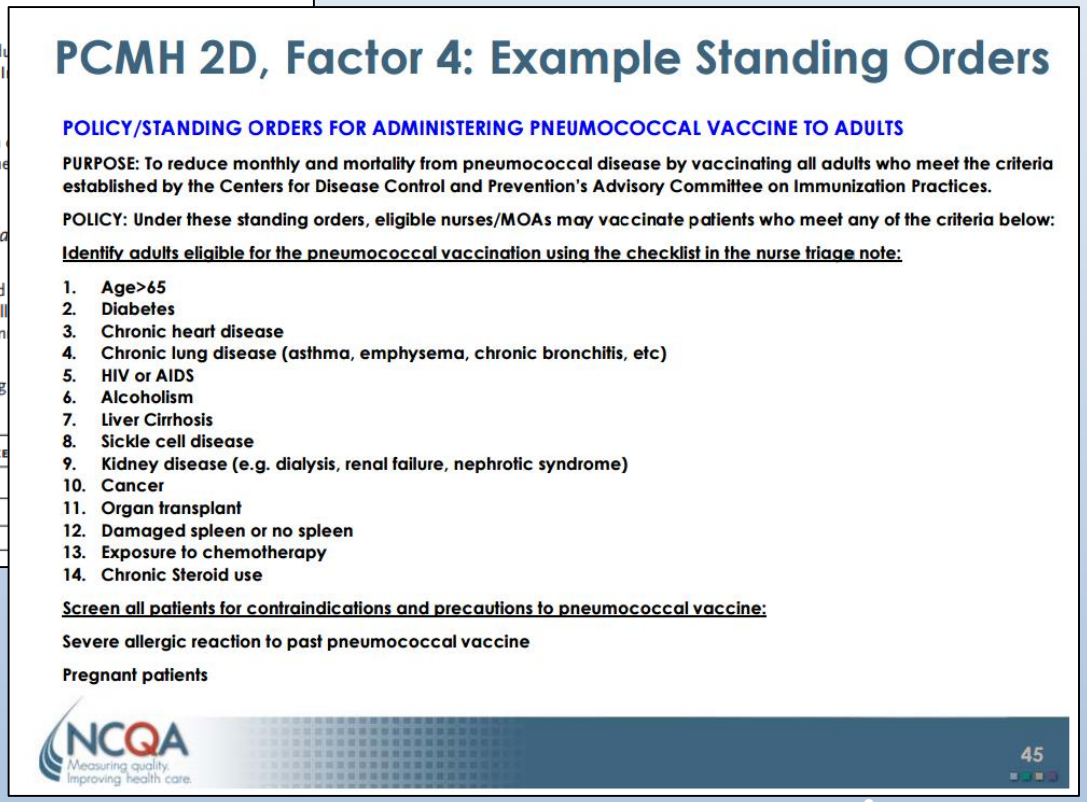
1 **Assess Adults for Need of Vaccination** against *Streptococcus pneumonia*
according to the following criteria:

Routine pneumococcal vaccination – Assess adults age 65 years or older for need
Pneumococcal conjugate vaccine (PCV13) should be administered routinely to all
age 65 years and older. Pneumococcal polysaccharide vaccine (PPSV23) is recom
years or older. For complete details, see section 5 (page 2).

Risk-based pneumococcal vaccination – Age 19 through 64 years with an underlying
factor as described in the following table:

CATEGORY OF UNDERLYING MEDICAL CONDITION OR OTHER RISK FACTOR	RECOMMENDED VACCINES ARE MARKE	
	PCV13	PPSV23
Chronic heart disease,[1] chronic lung disease[2]		x
Diabetes mellitus		x
Chronic liver disease, cirrhosis		x

Immunization Action Coalition



PCMH 2D, Factor 4: Example Standing Orders

POLICY/STANDING ORDERS FOR ADMINISTERING PNEUMOCOCCAL VACCINE TO ADULTS

PURPOSE: To reduce monthly and mortality from pneumococcal disease by vaccinating all adults who meet the criteria established by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices.

POLICY: Under these standing orders, eligible nurses/MOAs may vaccinate patients who meet any of the criteria below:

Identify adults eligible for the pneumococcal vaccination using the checklist in the nurse triage note:

1. **Age>65**
2. **Diabetes**
3. **Chronic heart disease**
4. **Chronic lung disease (asthma, emphysema, chronic bronchitis, etc)**
5. **HIV or AIDS**
6. **Alcoholism**
7. **Liver Cirrhosis**
8. **Sickle cell disease**
9. **Kidney disease (e.g. dialysis, renal failure, nephrotic syndrome)**
10. **Cancer**
11. **Organ transplant**
12. **Damaged spleen or no spleen**
13. **Exposure to chemotherapy**
14. **Chronic Steroid use**

Screen all patients for contraindications and precautions to pneumococcal vaccine:

Severe allergic reaction to past pneumococcal vaccine

Pregnant patients

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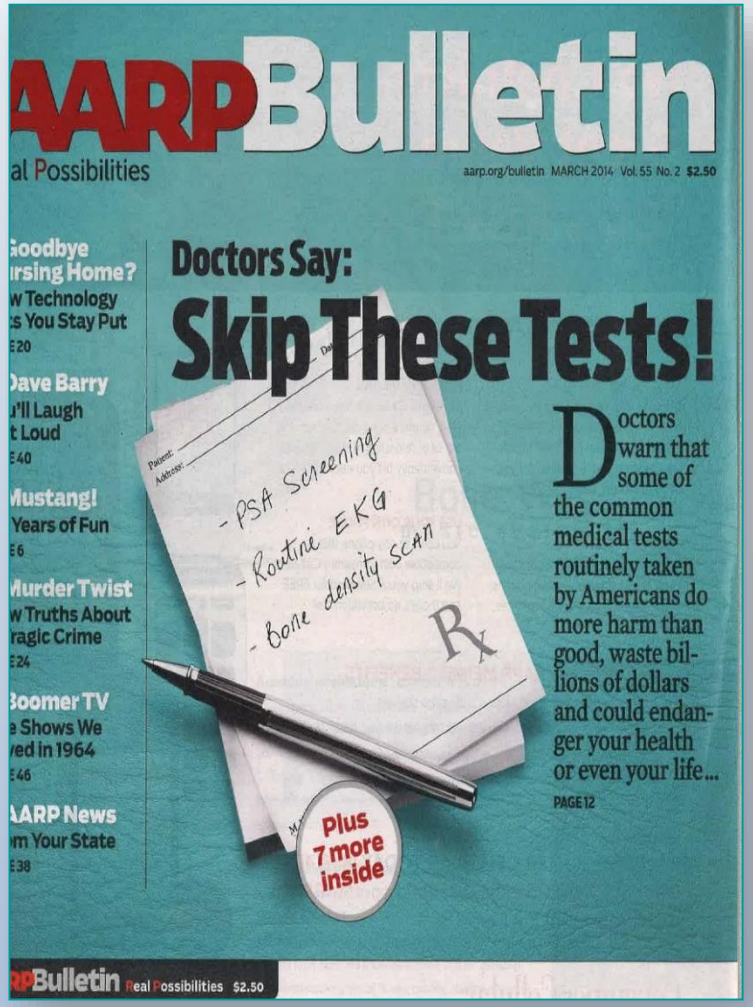
Step 3: Reduce Unnecessary Testing Based on Adopted Guidelines

- Some routine tests are not part of evidence-based guidelines
- Examples:
  - Prostate Testing
  - EKG
  - Routine Stress Test



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Outcomes Lead to Incomes

YEAR 1 - CLINICAL QUALITY PERFORMANCE

Clinical Metric	Year 0 Compliance Rate	Year 1 End Compliance Rate	Percentage Improvement
Breast Cancer Screening	68.33%	71.82%	5.10%
Colorectal Cancer Screening	56.82%	66.73%	17.45%
Diabetes: BP Control (<140/90 mm Hg)	57.98%	65.91%	13.68%
Diabetes: HbA1c Control (<8%)	60.39%	67.70%	12.11%
High Blood Pressure Control (<140/90 mm Hg)	66.12%	69.53%	5.16%
LDL-C Control (<100)	56.61%	66.49%	17.45%
Pneumonia Vaccination Status for Older Adults	47.45%	67.27%	41.76%
Tobacco Cessation Intervention	51.62%	98.60%	91.01%
Total Compliance Rate	56.60%	79.70%	40.81%

Year 1:
$1,752,632
Distributed to Providers

YEAR 2 - CLINICAL QUALITY PERFORMANCE

Clinical Metric	Year 2 Beginning	Year 2 Final	Percentage Improvement
Breast Cancer Screening	60.03%	77.94%	29.84%
Colorectal Cancer Screening	59.27%	72.84%	22.89%
Diabetes: BP Control (<140/90 mm Hg)	47.47%	79.40%	67.28%
Diabetes: HbA1c Control (<8%)	33.04%	63.03%	90.75%
High Blood Pressure Control (<140/90 mm Hg)	57.08%	81.41%	42.63%
LDL-C Control (<100)	16.00%	72.41%	352.59%
Pneumonia Vaccination Status for Older Adults	60.87%	85.38%	40.27%
Tobacco Cessation Intervention	22.88%	87.78%	283.73%
Total Compliance Rate	52.72%	75.82%	43.82%

Year 2:
$3,262,552
Distributed to Providers

KEY TARGETS
Does Not Meet Performance
50th Percentile
75th Percentile
90th Percentile

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Questions?

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Upcoming Webinars

4/11/17 12:00 PM – 1:00 PM EST

Establishing a Medical Neighborhood with

Mike Ruiz de Somocurcio and Lani Alison

Regional Cancer Care Associates

Register Now:

www.NJHCQI.org/GPTNwebinar_RCCA

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Save the Date

The Annual Innovation Showcase

hosted by NJII and the New Jersey Health Care Quality Institute

"**Using Technology to Transform the Practice of Medicine.**"

June 22, 2017 from 8:30 am to 4:30 pm

NJIT Campus Center

Registration will be complimentary for all GPTN members, Quality Institute members, NJAFP members, NJII External Advisory Board members, and Health IT Connections Entrepreneurs and Partners

Invitation and details to follow

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