Align Quality Improvement Initiatives with External Influencers to Foster Practice Transformation

Cari Miller, MSM, PCMH CCE
Director, Program Operations
New Jersey Academy of Family Physicians

CBI, September 2014
Learning Objectives

• Identify external influencers in the marketplace
• Explain how quality improvement programs were developed to address external influencers
• Identify details of the educational need of each project
• Discuss lessons learned
NJ AFP Experience

• National leader in continuing medical education, policy, and advocacy for family physicians and primary care in New Jersey

• Worked with more than 1000 internal medicine, family medicine, and multi-specialty practices/physicians to achieve Patient-Centered Medical Home (PCMH) recognition

• Led successful PCMH Pilot Project with Horizon Blue Cross Blue Shield of New Jersey (Horizon)

• Currently serving as Lead Faculty for CMS Compressive Primary Care Initiative
Primary Care Practices Today

- Too few resources
- Competing priorities
- Participating in various initiatives
- Varying comfort levels and experience with quality improvement (QI)

“There are just too many things going on, and I just can’t keep up, between CPC, PCMH, my ACO, and actually caring for patients, I feel like I am running on a hamster wheel...there needs to be better coordination between programs”

-Primary Care Practice
Some External Influencers

- Quality Improvement
- CMS/Federal Initiatives
- PCMH Requirements
- Health Plan/Local Initiatives
- ACO Requirements
External Influencers

• Federal programs
  – Comprehensive Primary Care (CPC) Initiative
  – Physician Quality Reporting System (PQRS)
  – Meaningful Use

• PCMH recognition

• Healthcare Effectiveness Data and Information Set (HEDIS)/health plan programs

• Accountable Care Organizations (ACO) initiatives
Level Setting: External Influencers
CPC Initiative

• Four year primary care demonstration project in seven regions across country
• Testing new primary care payment models related to
  – Care management
  – Quality and utilization improvement
  – Patient engagement
• Multi-payer involvement
  – Practice receive per member/per month fees for meeting specified metrics
PQRS

• CMS program
  – Payment incentive and adjustment program based on reporting of quality measures
  – Physicians/eligible providers (EPs) submit quality data to earn incentive payment
    • Potential to receive incentive payment equal to 0.5% of total estimated Medicare Part B charges for covered services furnished during reporting period
    • Those who do not satisfactorily report quality measure data in 2014 are subject to 2% payment adjustment for Medicare services provided in 2016
Meaningful Use (MU)

• Medicare and Medicaid electronic health record (EHR) incentive program
  – Financial incentives for MU use of certified EHR technology to improve patient care
  – Providers show they are meaningfully using EHRs by submitting reports to demonstrate they meet thresholds for a number of objectives
  – Must attest for MU every year to receive incentive and avoid payment adjustment

• Clinical Quality Measures - required to report clinical quality measures (CQMs) each year of participation to receive an incentive
PCMH Recognition

- National PCMH Recognition programs
  - Recognizes practices that are accountable for quality care by reporting evidence-based clinical metrics and patient experiences (retrospective review)
  - Practices report data on a physician/clinician and practice level
    - Often need to demonstrate improvement
    - Can select quality measures that are important to practice’s patient population
HEDIS/Health Plan Programs

- HEDIS is a tool used by more than 90% of health plans to measure performance on care and services.
- Consists of close to 100 measures.
- Makes it possible to compare performance of health plans on "apples-to-apples" basis.
- Health plans use HEDIS data to focus improvement efforts.
ACOs

• Groups of doctors, hospitals, and other providers, who come together to deliver coordinated high-quality care
  – Focus on coordinating care and communicating to ensure right care at right time to avoid service duplication and prevent medical errors

• Payment incentives often offered by Medicare, Medicaid and health plans to those providing quality care and reducing utilization of unnecessary services
  – Referred to as shared saving programs
So How Did We Use All of This Information?
Two Case Scenarios

• Pneumococcal Immunization Project
• Chronic Pain Management Project
Project

Improving Pneumococcal Immunization Rates in New Jersey through Collaboration

Issue: A substantial number of adults in NJ are not vaccinated against pneumococcal disease
Project Overview

• Goal: Increase pneumococcal vaccination rates for adults aged 18 or older
  – NJ’s rates among lowest in the country

• What we found
  – Practices unaware of site-specific rates
  – Practices’ leaders concerned due to ACO engagement, recognition programs, incentive programs (federal and local health plans)
  – Extensive challenges identified relating to communication/coordination with community immunization sources
Project Overview

• Recruited 20 practices
  – Intervention and control groups (10 practices each)

• Practices have to:
  – Submit baseline and re-measurement data
  – Develop and implement quality improvement plan
  – Focus on collaboration with external sources for communicating patient vaccination status to primary care practice
Recruitment

• Targeted practices with at least three external influencers

• Recruitment messages highlighted project would assist in meeting demands of external influencers
  – “A whole lotta birds, one stone”

• Sent to those responsible for quality metrics within practice

• Explicitly highlighted and provided information to address quality needs
Project Summary
Pneumococcal Vaccination Quality Improvement Collaborative

The Pneumococcal Vaccination Quality Improvement Collaborative is an initiative being offered by the New Jersey Academy of Family Physicians (NJAFP) to primary care practices in our state. It is designed to improve pneumococcal immunization rates for New Jersey adults. Increases in appropriate immunization will result in improved health and well-being of patients, as well as a reduction in healthcare costs through a decrease in avoidable hospitalizations and emergency department visits. **We have developed this project to assist practices meet the demands of several critical quality improvement initiatives, including PCMH recognition, ACO activities, health plan initiatives and federal programs such as PQRS and Meaningful Use.**

NJAFP will be working with approximately 20 practices that have achieved NCQA patient-centered medical home (PCMH) recognition and currently use an electronic health record system. Half of the practices will be randomly assigned to an intervention group and half to a control group. Practices selected for the intervention group will receive education and training and submit data; the control group will be asked to submit data twice during project implementation and complete a participation survey. All practices selected to participate will receive an honorarium.

Physicians and practice staff selected to participate in the intervention group will attend three learning sessions throughout the project period. Working as a multi-disciplinary care team, staff and physicians will receive free training in areas, such as motivational interviewing, and use of standing orders and registries to assist in enhancing current vaccination practices. Learning sessions will also include the identification of community resources and the development of collaborations with these entities designed to reduce system and patient barriers and, thereby, increase pneumococcal vaccination rates.
Interventions

• Modeled after Institute for Healthcare Improvement Learning Collaboratives
  – Three learning sessions and three action periods
  – Learning sessions provide resources (tool kits, packets) opportunity to share best practices among participants

• During action periods NJAFP Project Facilitator goes on-site to practice
  – Reviews QI plan
  – Meets with team
  – Addresses any barriers
  – Continue to link project to practice’s external influences’ requirements
Engagement

• Explicitly highlighted and provided information to address quality needs
  – Built education with practices’ needs/gaps in mind
    • Gaps in evidence-based guidelines
      – Immunization recommendations for ages 19-64
    • Provided tools/resources to assist in collaboration and communication with external partners
      – Telephone scripts, email messages, letters, processes
    • Focused on fostering team-based approach to care
      – Population health management training
      – Standing orders
Engagement (cont.)

• If providing value and needed services (helping practice address external influencers), participants more likely to remain engaged
  – Became a valued resource for participants
Milestone 5: Quality Improvement

Intent of Milestone 5
The intention of Milestone 5 is to help your practice take a systematic approach to using data from and about the practice to improve care. In PY 2013, your practice identified measures for quality and utilization that are important to your practice and patients. Your practice used the measure as a guide while you tested changes in your practice. In PY 2014, the work in this Milestone supports your continued work to improve quality of care as measured by the CPC Clinical Quality Measures (CQMs).

In PY 2014, the work in this Milestone aligns with and supports the requirement for reporting quality of care at the practice level using the CPC EHR-based Clinical Quality Measures. Starting PY 2014, your practice’s ability to report the EHR-based CQMs will affect your eligibility for any shared savings to Medicare gained by your CPC region. Your practice will need to know that at the end of the year you can demonstrate better care and improved health outcomes for your patients.

Focus on Three Clinical Quality Areas
In addition to continuing to report the CQMs at the practice level, the work in this Milestone is to use the CQM data, on at least a quarterly basis, to focus improvement efforts on at least three areas of clinical quality that impact care and health outcomes for your patients. Improvement in care requires a change in care by the provider and care team. We ask that your practice measure clinical quality using the CQMs for each provider or care team (depending on how the practice is organized) and give that data in an actionable format to the provider/care team to guide improvement in quality. Each quarter, your practice can continue to focus on the
<table>
<thead>
<tr>
<th>#111 (NQF 0043): Preventive Care and Screening: <strong>Pneumococcal</strong> Vaccination for Patients 65 Years and Older</th>
<th>4040F</th>
<th>4040F-1P</th>
<th>4040F-8P</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pneumococcal vaccine administered or previously received</td>
<td>Documentation of medical reason(s) for not administering or previously receiving pneumococcal vaccination</td>
<td>Pneumococcal vaccine was <strong>not</strong> administered or previously received, reason not otherwise specified</td>
</tr>
</tbody>
</table>

- **Clinician** OR **G0919**
- Influenza immunization ordered or recommended (to be given at alternate location or alternate provider); vaccine not available at time of visit

- **Administered, reason not given**
Pneumonia Vaccination Status for Older Adults (NQF 0043)

This report measures the percent of patients over the age of 65 who have received a pneumococcal vaccine.

Patient Population: The initial patient population for this measure includes all patients who are 65 years of age or older during the measurement period.

Exclusions: None.

The system uses the following steps to calculate the percentage:

1. Patients who have seen the provider within the calendar year prior to the end of the measurement period. Determine the number of patients in the patient population that have seen the provider during the calendar year prior to the end of the measurement period.

2. Patients who received the pneumococcal vaccine. Determine the number of patients in the patient population who were administered the pneumococcal vaccination.

3. Divide the value in step 2 above by the value in step 1 above. The result is then multiplied by 100 to achieve the percentage.

Note: The following items apply to this report:
- All patients included on the report for a specific provider must have that provider designated as the primary provider in the Care360 EHR system. To specify a primary provider for a patient, see Add a New Patient Manually or Managing Patient Details.
- Patients with an inactive or deceased status are excluded from all Meaningful Use reports.
Element C: Comprehensive Health Assessment

To understand the health risks and information needs of patients/families, the practice collects and regularly updates a comprehensive health assessment that includes:

1. Age- and gender appropriate immunizations and screenings.
2. Family/social/cultural characteristics.
3. Communication needs.
4. Medical history of patient and family.
5. Advance care planning (NA for pediatric practices).
7. Mental health/substance use history of patient and family.
8. Developmental screening using a standardized tool (NA for practices with no pediatric patients).
9. Depression screening for adults and adolescents using a standardized tool.
10. Assessment of health literacy.

<table>
<thead>
<tr>
<th>Scoring</th>
<th>100%</th>
<th>75%</th>
<th>50%</th>
<th>25%</th>
<th>0%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The practice meets 8-10 factors</td>
<td>The practice meets 6-7 factors</td>
<td>The practice meets 4-5 factors</td>
<td>The practice meets 2-3 factors</td>
<td>The practice meets 0-1 factors</td>
</tr>
</tbody>
</table>

Yes  No  NA
Training Slide

- Use activities to meet PCMH requirements
  - PCMH 1 G # 6
    - Practice uses team to provide range of patient care services by training and assigning care teams for patient population management
  - PCMH 1 G # 3
    - Practice uses team to provide range of patient care services by using standing orders
  - PCMH 2 D # 1
    - Practice uses clinical data and evidence-based guidelines to generate lists of patients to proactively remind patients and clinicians of services needed for three different preventive services
**Table 1 (continued)**

Measures for use in establishing quality performance standards that ACOs must meet for shared savings

<table>
<thead>
<tr>
<th>ACO #</th>
<th>Measure title</th>
<th>NQF #</th>
<th>Measure steward</th>
<th>Method of data submission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain: preventive health</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PREV-5</td>
<td>Breast cancer screening</td>
<td>NA</td>
<td>NCQA</td>
<td>QMAT/WI</td>
</tr>
<tr>
<td>(ACO-20)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PREV-6</td>
<td>Colorectal cancer screening</td>
<td>0034</td>
<td>NCQA</td>
<td>QMAT/WI</td>
</tr>
<tr>
<td>(ACO-19)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PREV-7</td>
<td>Preventive care and screening: influenza immunization</td>
<td>0041</td>
<td>AMA/PCPI</td>
<td>QMAT/WI</td>
</tr>
<tr>
<td>(ACO-14)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PREV-8</td>
<td>Pneumonia vaccination status for older adults</td>
<td>0043</td>
<td>NCQA</td>
<td>QMAT/WI</td>
</tr>
<tr>
<td>(ACO-15)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PREV-9</td>
<td>Preventive care and screening: body mass index screening and follow-up</td>
<td>0421</td>
<td>QIP</td>
<td>QMAT/WI</td>
</tr>
<tr>
<td>(ACO-16)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PREV-10</td>
<td>Preventive care and screening: tobacco use:</td>
<td>0028</td>
<td>AMA/PCPI</td>
<td>QMAT/WI</td>
</tr>
<tr>
<td>(ACO-17)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### HEDIS 2013 Summary Table of Measures, Product Lines and Changes (continued)

<table>
<thead>
<tr>
<th>HEDIS 2013 Measures</th>
<th>Applicable to:</th>
<th>Changes to HEDIS 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Commercial</td>
<td>Medicaid</td>
</tr>
<tr>
<td>Effectiveness of Care</td>
<td></td>
<td>Medicare</td>
</tr>
<tr>
<td>Aspirin Use and Discussion</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Flu Shots for Adults Ages 50–64</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Flu Shots for Older Adults</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Medical Assistance With Smoking and Tobacco Use Cessation</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Pneumococcal Vaccination Status for Older Adults</td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>

### Access/Availability of Care

<table>
<thead>
<tr>
<th></th>
<th>Applicable to:</th>
<th>Changes to HEDIS 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults' Access to Preventive/Ambulatory Health Services</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Children's and Adolescents' Access to Primary Care Practitioners</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>
So How Many Boxes Did Project Check-Off?

✓ Federal programs
  ✓ Comprehensive Primary Care Initiative
  ✓ Physician Quality Reporting System (PQRS)
  ✓ Meaningful Use

✓ PCMH recognition
  ✓ NCQA

✓ Health plan programs/HEDIS
✓ ACO initiatives
Project Successes

• All practices remained engaged throughout entire project

• Huge immunization rate increases from every practice
  – Many practices demonstrating improvement rates of 25% to 35%

• Recent education session each practice shared lessons learned and best practices to further drive improvements
Project

Engaging the Entire Care Team to Facilitate a Comprehensive Pain Management Program in the Primary Care Setting

Issue: Primary care physicians and practice teams have a need to improve knowledge, skills and competencies in the area of pain management to foster enhanced patient care, satisfaction and outcomes
Recruitment

• Focused on practices
  – Participating in CPC project
  – Renewing PCMH recognition

• More than 30 practices interested in participating
  – Project limited to 10 practices
  – To participate practices had to complete and sign Letter of Participation
  – Final group of practice selected based on external influencers
Recruitment

New Jersey Academy of Family Physicians
Chronic Pain Management Project:
Integration of Behavioral Health into Primary Care

Project Overview
The New Jersey Academy of Family Physicians (NJAFP) has received a grant of funding to conduct a unique and valuable project focusing on improving chronic pain management in primary care practices. NJAFP can work with a limited number of practices by providing education, hands-on assistance, and a small monetary stipend to practices that participate in this 10 month project (April 2014 – January 2015). Practices participating in the Comprehensive Primary Care (CPC) Initiative can use project activities to meet Milestone 2: Integration of Behavioral Health. In addition, practices could meet NCQA PCMH Standard 6 requirements through project activities.

Overall Goals and Objectives
Develop and deploy behavioral health integration into practice to assist physicians and care teams improve knowledge, skills and competence in chronic pain and pain management to foster enhanced patient care, satisfaction and outcomes. The focus will be on patients who present with chronic lower back pain or knee pain. The key objectives for this initiative are to:
1. Develop and implement a program for primary care teams to foster enhanced ability and confidence to appropriately treat and manage patients who present with pain based on current evidence-based (EB) guidelines
2. Increase use of EB guidelines, screening tools and treatment options for patients with pain in primary care setting
3. Introduce or enhance primary care teams quality improvement (QI) and population health management abilities to assist in effectively treating and managing patients with pain
Interventions

• Short project time frames
• One kick-off learning session
• On-site NJAFP Project Facilitator visits
  – Review of QI plan
  – Address challenges
  – Assesses progress to date
  – Assists practice in connecting project activities to external influencers’ requirements
  – Provides materials/tools as needed
Engagement

• All practices actively engaged
  – Completed baseline data chart review and submission and patient experience survey

• Aligned resources for project with external influencer requirements
  – Provided resources to practices to maximize staff, time and efforts
    • Standardized pain assessment tools
    • Patient experience surveys
Results to Date

• 100% participation in kick-off meeting
  – Physicians and practice team

• Currently conducting site visits to practices (seven of 10 completed)

• Of the 10 practices
  – Seven already used project and resources for quarterly CPC submission requirements
  – Three in process of using information for PCMH submission
Engagement - Is this practice actively engaged/participating in Pain Management Improvement Collaborative?

- Practice appears to be engaged, provided examples and documentation to support participation in project activities

- Practice presented solid plans, can produce documentation of participation, such as regular staff communication/meetings, has attended learning sessions, team participated and engaged during Facilitator visit
Results To Date

Please list the activities the practice has made conducted since the May 6 kick off meeting:

Answered: 7   Skipped: 0

- Completed quality measures
- Distributed patient...
- Had at least one team...

Answer Choices

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completed quality measure baseline data submission</td>
<td>100.00%</td>
</tr>
<tr>
<td>Distributed patient satisfaction surveys</td>
<td>100.00%</td>
</tr>
<tr>
<td>Had at least one team meeting</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

Total Respondents: 7

Comments (3)
Summary

• Aligning with external influencers is critical for success!

• Communicate
  – Explain how project aligns with organizational priorities
  – Clearly and concisely identify benefits of participation
    • Identify how project supports/coincides with work of practice e.g., external influencers

• Outline how participation assists in mitigating current pain related to competing priorities established by various external influencers
Summary

• Build program with practices’ needs in mind
  – Give ‘em what they need to meet demands of external influencers
    • Provided tools/resources to assist in collaboration and communication with external partners
      – Telephone scripts, email messages, letters, processes
    • Fostering team-based approach to care and provided
      – Population health management training, Standing orders

• Providing value by addressing demands of external influences for primary care practices helps ensure engaged participants and project success
Contact Information
Cari Miller, MSM, PCMH CCE
Director Program Operations
New Jersey Academy of Family Physicians
224 West State Street
Trenton, NJ 08608
Phone: 609-394-1711
Fax: 609-394-7712
www.njafp.org