St. Rose Quality Care Network
A Dignity Health Member

Winter 2018

What's New in Clinical Integration

SRQCN'S QUARTERLY NEWSLETTER FOR PARTICIPATING PROVIDERS

INSIDE THIS ISSUE

First Look: The Clinical Steering Committee's New Charter

The Population Health Management Clinical Steering Committee has encapsulated its purpose in a new charter: to provide clinical governance and oversight to population health activities consistent with the mission of Dignity Health in providing compassionate, high-quality, affordable health services.

Over the past several months, we have worked to reformat the Clinical Steering Committee to be more inclusive of the MSSP and CIN physicians at Dignity Health, and adopt a standard approach to the clinical management of patients in value-based agreements and population health across Dignity Health. The charter spells out five primary functions that fall under the Clinical Steering Committee:

1. Guiding the clinical direction, priorities, and focus of population health activities across the Dignity Health Enterprise.
2. Providing oversight, coordination, and governance activities between the clinical steering committees, various sub-committees and work groups, including:
   - Practice transformation
   - Care coordination
   - Quality and chronic disease management
   - Data and analytics
3. Maintaining a constant focus on the Quadruple Aim for Health Care:
   - Better outcomes
   - Improved efficiency and lower costs
   - Improved patient experience
   - Improved clinician experience
4. Removing systemic barriers to care and progress for population health activities.
5. Partnering with Dignity Health support partners such as Legal, Information Technology, the Office of Digital and the Executive Clinical Council to achieve best outcomes for a collaborative patient-centric approach to health and health care.

Opioid Toolkit Now Available

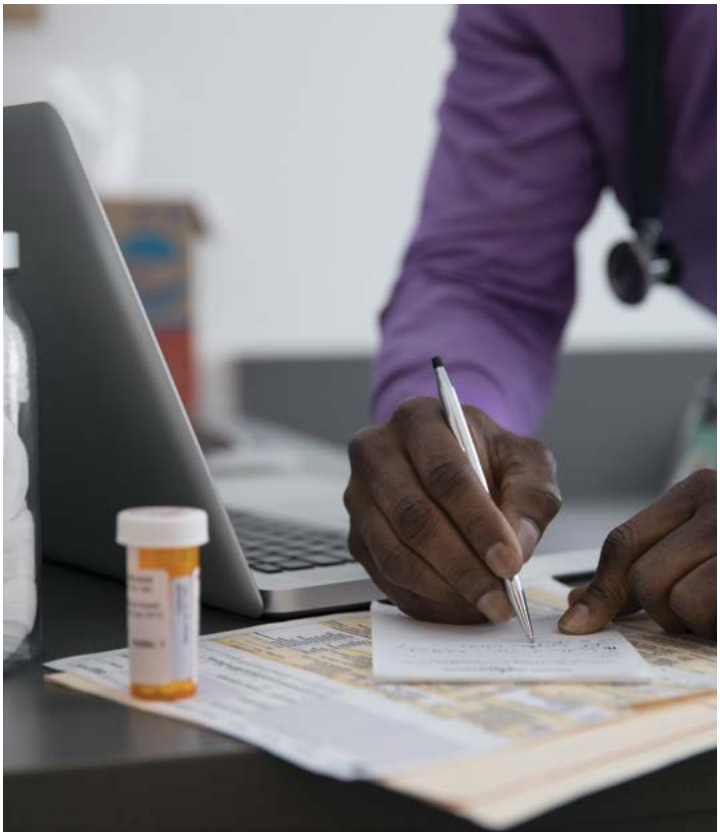
As a physician, you play an important role in treating your patients' pain while ensuring their safety and helping to reduce the risk of opioid misuse. Before prescribing an opioid medication, it's important to understand a patient's personal risk for misuse and to communicate clearly with the patient about the risks associated with opioids.

The clinically integrated networks' Opioid Task Force has assembled a useful Opioid Toolkit to assist you. In it, you'll find:

- Opioid checklist and prescribing guidelines
- A risk assessment tool
- Controlled substance patient information form and agreement (for acute and chronic patients)
- CDC guidelines for prescribing opioids
- Additional information about the opioid epidemic

The Opioid Toolkit assists providers with an organized and legally compliant approach to the prescribing and monitoring of patients who require controlled substances.

Download the toolkit now



Peer Evaluation Survey Results Coming Soon

During the past several months, physician leaders from across the Dignity Health clinical integration networks have worked together to align their quality and performance improvement programs with value-based agreement models, including MSSP and the Medicare Incentive-Based Payment Programs (MIPS). In addition to *measurement*, foremost in the care process is how we as physicians communicate and collaborate.

We have discussed the importance of excellent communication and collaboration between the members of the medical community as we care for patients, and transparency and accountability in medical practice.

To this end we believe that we can benefit from constructive peer feedback regarding how our colleagues perceive their interactions with us and vice versa. That's why we conducted a pilot peer evaluation project consisting of a brief (three- to five-minute) web-based peer evaluation process.

You recently received a survey link. This web-based survey allows primary care physicians to provide feedback to specialists, and vice versa. When available, you will receive a confidential copy of your feedback, which your CIN's medical director also will see. The results will not be used for any other purpose than to provide you with feedback as to how your work with others in the medical community is perceived.

We see this work as both a learning opportunity and a pilot, focused on how we can improve and how we work and collaborate together. You'll learn more about the results and insights we gleaned in the months ahead. Thank you for your participation.

Care Coordination Program: New Structure, New Approach

During the past several months a multidisciplinary team has worked to create a standard approach across Dignity Health for ambulatory complex care coordination. The recently restructured Dignity Health Care Coordination Program is here to help patients reach their health goals by connecting them with key resources and ensuring they get the clinical services support they need.

Developed utilizing evidence-based, scientifically supported practice resources to improve health outcomes, the goals of Care Coordination are to:

- Help the patient regain or maintain optimum health or improved functional capability.
- Encourage patients to participate and to augment positive health outcomes and satisfaction.
- Educate providers about all care coordination programs with the latest protocols.
- Encourage providers to refer patients to the appropriate programs.

This is a voluntary program that includes assessment, facilitation, evaluation, care planning and care coordination to meet the comprehensive medical, behavioral health and psychosocial needs of the individual while promoting quality and cost-effective outcomes.

Services vary, based on where a patient is in his or her health journey. The Care Coordination program is divided into four categories:

1. Wellness/Stable
2. Rising Risk
3. Complex Care
4. Palliative Care

The purpose of this category system is to subdivide patients requiring minimal or short-term intervention from those needing prolonged care coordination services. The categories allow for improved tracking and monitoring of patient care progress. A patient may transition between any of the care coordination categories. Once a Rising Risk, Complex Care or Palliative Care patient is enrolled, Care Coordination will continue services until either the provider or patient discontinues the services.

The Care Coordination program is not intended to replace or substitute physician management of the patient's medical conditions. Care Coordination will collaborate with the practitioner to coordinate clinical and support services for patients to decrease the potential for fragmentation of care.

The program is available to the Dignity Health patient population served; however, outreach efforts may focus on a particular population, depending on regulatory requirements and identified population needs. The following are examples of a focused population:

- All value-based agreement members
- MSSP patients
- Members who are chronically ill

Group Physician Reporting Option (GPRO) Update

Dignity Health has four accountable care organizations (ACOs), which must track data for 31 required quality initiatives (related to clinical, administrative and patient satisfaction).

Within this program, there is an opportunity to share cost savings among provider members when specific goals and benchmarks are met, so data collection is critical.

Group Physician Reporting Option (GPRO) offers quality data collection, measurement and reporting at the ACO level within the MSSP. Here's how it works:

- The samples for which an ACO will need to submit clinical quality data will be drawn from all assigned beneficiaries across the entire ACO (all participating TINS). There is one set of samples drawn from the entire ACO, not one for each participating TIN. Samples are selected from the third-quarter beneficiary assignment.
- Providers in the ACOs must use the GPRO web interface for the required measures. CMS will pre-populate the sample patient population from the entire ACO with 616 beneficiaries for each measure (750 for statin therapy for cardiovascular disease).
- You are required to report a minimum of 248 consecutive beneficiaries for each measure (or 100 percent if you have fewer than 248 eligible beneficiaries). A beneficiary is assigned to the ACO if he or she had at least one primary care visit with a participating provider between Jan. 1 and Oct. 31, 2017.

When results are available, we'll share them with you, along with information on areas of improvement, suggested action plans for improvement, education on best practices and more. For questions about GPRO, please contact Kelly Bitonio at **kelly.bitonio@dignityhealth.org**.

Are You Ready for Medicare Annual Wellness Visits?

The Medicare Annual Wellness Visit process is designed to provide an opportunity for patients and providers to review several important aspects of care for the patient. Components of the Annual Wellness Visit include a risk assessment related to such things as falls, health habits including smoking, depression and lifestyle.

The visit, which is questionnaire-based, creates an opportunity for a complete review of each patient's chronic medical conditions, while at the same time creating a plan for care with goals focused on these same chronic medical conditions for the coming year.

Lastly, the Annual Wellness Visit is designed to assist providers in appropriately coding these same chronic conditions for purposes of Medicare HCC Coding and Risk Adjustment Factor (RAF) scores. **Annual Wellness Visits (AWVs)** help us serve our patients and communities while meeting quality goals and in the process delivering a reimbursable service.

The AWV is a combination of three visit types – the Initial Preventative Physical Exam, the Initial Annual Wellness Visit and the Subsequent Annual Wellness Visit. Each visit type has a unique set of requirements and benefits.

To learn more about the specifics of each type of visit and what's included, and to see a sample Health Risk Assessment Tool used during a wellness visit, download the **SRQCN Medicare Annual Wellness Guide** today.

Reminder: New Hypertension Protocols in Place

One of our key quality measures is focused on controlling high blood pressure, as we track the percentage of patients ages 18 to 85 with HTN whose blood pressure is adequately controlled (<140/90). Hypertension can lead to myocardial infarction, stroke, renal failure and death if not detected early and treated appropriately. Patients want to be assured that blood pressure treatment will reduce their disease burden, while clinicians want guidance on hypertension management using the best scientific evidence.

For this measure, you are asked to complete a blood pressure reading and record it in the EHR at every visit for patients who have an active diagnosis of hypertension. The measure includes patients whose blood pressure at the most recent visit is adequately controlled (<140/90) during the measurement period.

Although these guidelines provide evidence-based recommendations for the management of hypertension and will meet the clinical needs of most patients, they are not a substitute for clinical judgment; and decisions about care should incorporate recommendations for high-risk clinical conditions and the circumstances of the individual patient.

Get more details on the **hypertension protocols now**.

How to Meet ACI Measurement Requirements

One quality measure we're looking at is the percentage of eligible clinicians (ECs) participating in the ACO who successfully meet the Advancing Care Information (ACI) Base Score.

To meet ACI measure requirements, clinicians should follow these steps:

1. Contact your EHR vendor for guidance on how to meet the ACI measure requirements using your specific EHR.
2. Determine which ACI measure set you/your group should report, based on whether your EHR meets 2014 or 2015 Medicare certification requirements.
3. If you are reporting as a group, aggregate the measure data for each of the MIPS-eligible clinicians that bill under your group's TIN (data for certain clinicians can be excluded). If you are reporting individually, skip this step.
4. CMS has required each ACO participant to establish an Enterprise Identity Data Management (EIDM) portal to report the measures via attestation and your EHR Note that one of the required ACI measures is successful completion of a Security Risk Analysis.
5. In case of an audit, keep a binder with records of all the information related to reporting the ACI measures.

To learn more about ACI, download **SRQCN's Best Practices for Reporting the MIPS Advancing Care Information Category in 2017.**

Save the Date: Annual Business Meeting Coming in May

The SRQCN Annual Business Meeting will be held from 5:30 to 8:30 p.m. on Thursday, May 10 at Gaetano's Ristorante in Henderson.

Be on the lookout for both email and postal mail invitations in the next couple of months. The meeting's agenda includes:

- Board of Managers voting
- MSSP Year 2
- MACRA/MIPS update

There are four positions open on the Board of Managers. These roles have three-year terms that begin in July. If you are interested in being a nominee, please contact Dr. Robert Pretzlaff **(robert.pretzlaff@dignityhealth.org)** or Dr. Teresa Hong **(teresa.hong@dignityhealth.org).**

SRQCN Annual Business Meeting

Time: 5:30 to 8:30 p.m.

Date: Thursday, May 10

Location: Gaetano's Ristorante
10271 S. Eastern Ave, #111
Henderson, NV 89052

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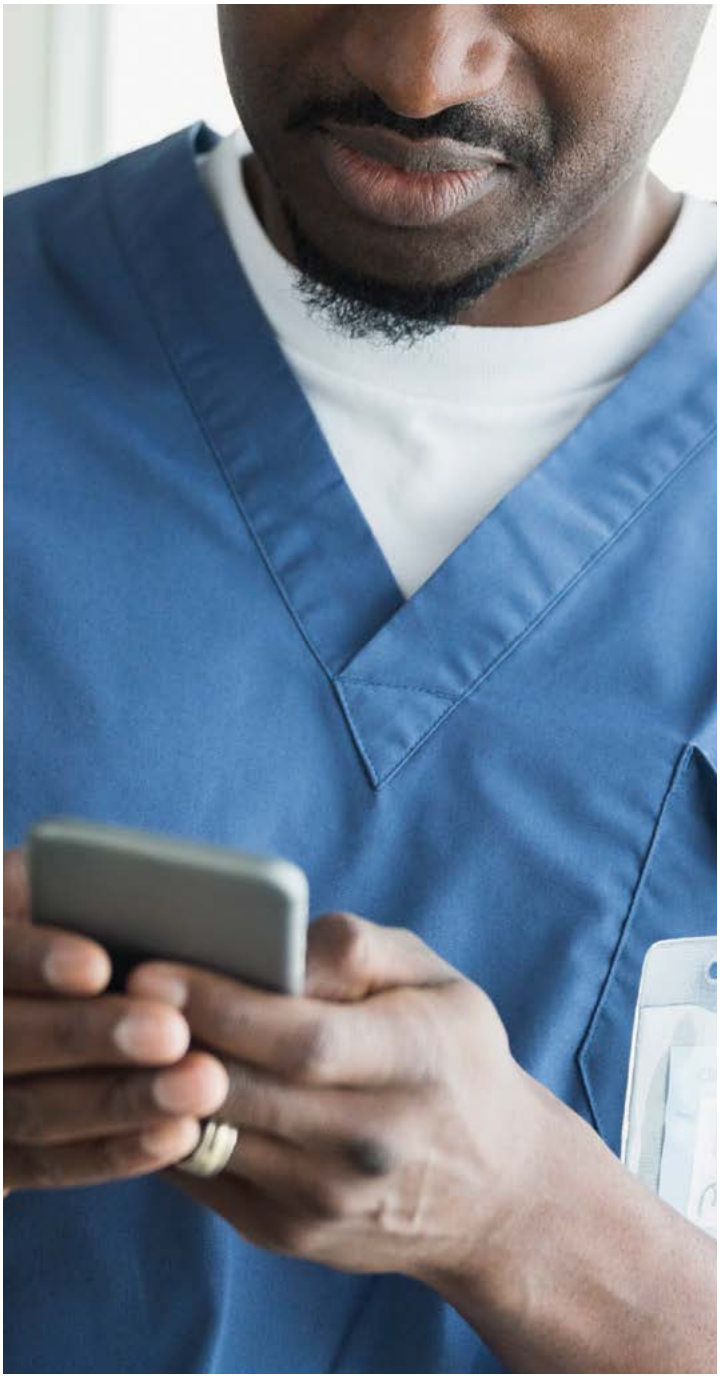

Sign Up for Text Alerts. Stay In the Know.

Never miss important news from SRQCN. With our new text alerts, you'll always be in the know and spend less time in your email inbox. You'll get an alert when there's important network news and announcements. (The system is fully HIPAA-compliant, and patient data will never be sent.) So, whether you're frequently on the go or simply prefer texts, text alerts make it easier to stay up to speed.

If you want to sign up to receive the text alerts, simply use your mobile phone and text "SRQCN" to "797979"

Physician Leadership

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Shane Flaviano, MD
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Raji Venkat, MD

Payer Committee
Dara Welborn, MD – Chair
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Scott Manthei, DO
Raji Venkat, MD
Sanford White, MD

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Scott Selco, MD – Chair
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Chandra Narala, MD
Matt Treinen, DO

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Dennis Chong, MD
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Gaurav Jain, MD
Kim LaMotte-Malone, MD

Performance Evaluation Committee
Donna Miller, MD – Chair
Joseph Adashek, MD
Szu Nien Yeh, MD
Anna Salcedo, MD
Colby Young, MD

Mission Statement

The mission of the St. Rose Quality Care Network is for its physician members, in collaboration with their hospital partners, to improve the health of the community through the efficiency and effectiveness of the care they deliver, monitoring outcomes across the health care continuum, and focusing on improvement of processes and appropriate utilization to ensure quality.

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