St. Rose Quality Care Network
A Dignity Health Member

V. 1 / NO. 3

What's New in Clinical Integration

SRQCN'S QUARTERLY NEWSLETTER FOR PARTICIPATING PROVIDERS

INSIDE THIS ISSUE

MIPS Quality Measures for Annual Wellness Exams: A Quick Reference Guide

Fellow CI Physician,

We all know that annual wellness visits are an important part of primary care. The Centers for Medicare and Medicaid Services (CMS) recognizes this as well, and has outlined specific quality measures tied to those visits.

As part of our Merit-based Incentive Payment System (MIPS) participation, it's important that St. Rose Quality Care Network (SRQCN) providers satisfy the annual wellness visit measures. That means completing each element of the wellness visit when you see a Medicare patient and documenting the completed steps.

Our goal as a clinically integrated network is to provide coordinated high-quality care to all of our patients. Our various initiatives – par8o, the Diabetes Initiative Program, the Senior Peer Counseling Program, etc, – are geared toward our MSSP patients, ensuring they receive excellent coordinated care. And from the preliminary numbers, we are indeed starting to see improvement in terms of outcomes.

That's great news on several levels. First of all, we're hearing positive feedback from our patients. They're saying they're pleased with the care they receive from their SRQCN physicians, and as doctors, that's ultimately what we want. From a business perspective, we're seeing more patients coming to us, and the improved outcomes ultimately contribute to our value-based care payments as well.

You have a lot on your mind when you're seeing patients, so we've included an at-a-glance guide to annual wellness exams, from how to differentiate between initial preventive exams, annual exams and subsequent exams to what should be included in each exam. I encourage you to print out and laminate these pages and keep them in an easy-to-reference place.

As always, thank you for being a part of SRQCN and helping us achieve our goals.

Sincerely,

Teresa Hong, MD
Medical Director

An Overview of Annual Wellness Visits for Medicare Patients

	Initial Preventative Physical Exam (IPPE)	First Annual Wellness Visit (AWV)	Subsequent Annual Wellness Visits (AWV)
Purpose	Intro to Medicare benefits, disease prevention	Update of medical and social, coordinate preventive screenings	Annual review of chronic conditions, preventive screenings
Eligibility	Within the first 12 months of Medicare Part B eligibility	After 12 months of Part B eligibility and more than 12 months since an IPPE (this is a once-per-lifetime service)	Every year after the first AWV (each AWV must be 11 full months after the month of the last AWV)
Major components	• Personalized preventive plan of service (PPPS)	• Update (PPPS) • Update HRA	• Review status of all chronic conditions • Review preventive care • Document and code all HCCs
Diagnoses	Z00.00 — Normal findings Z00.01 — Abnormal findings Others as appropriate	Z00.00 — Normal findings Z00.01 — Abnormal findings Others as appropriate	Z00.00 — Normal findings Comprehensive
Billing code	G0402	G0438	G0439
Depression screen	Z13.89	Z13.89	213.89
Reimbursement	$150 (2013)	$170.00	$110

Detailed List of Minimum Required Components

IPPE	First AWV	Subsequent AWV
Obtain and document medical and surgical history and family history		Update medical and surgical history
Document current medications and supplements		
Document height, weight, body mass index, blood pressure and visual acuity		Document height, weight (or waist circumference, if appropriate) and blood pressure
Review fall screening and risk factors for depression and other mood disorders		
Review patient's functional ability and level of safety		
	Assess the beneficiary's cognitive function	
	Establish a list of the beneficiary's risk factors, conditions and treatment options	Update the list of risk factors, conditions and recommended interventions
Provide end-of-life counseling and planning (following patient consent).		
	Establish a list of current providers and suppliers involved in the patient's care	Update list of current providers and suppliers involved in the patient's care
Establish a written plan for other preventive screening services (e.g., ECG, mammogram).	Establish a written screening schedule of preventive services for the next five to 10 years	Update the written screening schedule
Provide education, counseling and referrals based on the components of the visit	Provide personalized health advice and referrals for preventive counseling	Provide personalized preventive health advice and referrals as indicated

Understanding MIPS Advancing Care Information

As you know, the Merit-Based Incentive Payment System (MIPS) is a new reimbursement system for clinicians billing Medicare. MIPS scores clinicians on their performance in the following categories:

- Quality
- Cost
- Improvement activities (such as care coordination and population health management)
- Advancing care information (ACI)

Starting in 2019, clinicians' Medicare reimbursement will be adjusted based on their performance in these four categories. Performance data from 2017 will be used to determine payment adjustment in 2019. Clinicians can choose to participate in MIPS as an individual or a group. A group is defined as two or more clinicians who bill under the same tax identification number (TIN).

The Advancing Care Information (ACI) category within MIPS replaces the Meaningful Use (Electronic Health Record Incentive) Program, and promotes the electronic exchange of health information. The ACI score comprises 30 percent of an MSSP clinician's total MIPS score in Performance Year 2017.

Every practice in the SRQCN MSSP ACO is required to report on the Advancing Care Information category. Clinicians report at the practice TIN level. TIN scores will be combined as a weighted average based on how many MIPS-eligible clinicians are in each TIN, yielding one score for the entire ACO. All clinicians in the ACO will receive the same score.

A practice's ACI score will be calculated by combining three score components: the base score, the performance score and bonus points.

The following are the steps you should follow to report data for the Advancing Care Information category:

1. Contact your EHR vendor for guidance on how to meet the ACI measure requirements using your specific EHR system.
2. Determine which measure set your practice should report, based on whether your EHR meets 2014 or 2015 CMS requirements.
3. Aggregate the measure data for each of the MIPS-eligible clinicians that bill under your practice's TIN (data for certain clinicians can be excluded).
4. Report the measures via attestation, your EHR, a Qualified Clinical Data Registry, a Qualified Registry, or the CMS Web Interface.
5. Document the whole process in case of an audit.

For more details on ACI and reporting ACI, download our guide: Best Practices for Reporting ACI.

par8o's Community Health Programs Support Your Patients

When your patients are managing chronic illnesses or struggling with a health issue, they often need education and support from multiple sources. As their physician, you do a lot, but you can't do everything. But the various community health programs in our area can bridge the gap, helping your patients get the quality care they need.

Over the last few months, SRQCN leadership and Dignity Health have been working to facilitate more robust referral opportunities to community programs that meet the needs of both practice groups and patients. The addition of community programs to the Diabetes Initiative (see more on page 6) within our current referral management tool, par8o, enables referring and matching patients to the educational programs available in the SRQCN community.

Programs are available to help patients access:

- Prediabetes and diabetes education
- Chronic disease self-management
- Fitness classes
- Outpatient nutrition education
- Women, Infants, and Children (WIC) services
- Senior peer counseling

How to Refer a Patient to a Community Program

The St. Rose Quality Care Network (SRQCN) encourages you to use par8o for referral management for your Traditional Medicare patients – whether you're referring to another physician or to a community program. The par8o platform offers a seamless, simplified referral process. You can also track the lifecycle of the referral, speeding follow-up time and enhancing the efficiency of care.

For questions about par8o or your par8o account, contact par8o Support at support@par8o.com.

Diabetes Initiative Program Referrals: An Overview

The SRQCN Diabetes Initiative was designed to enhance physician collaboration with the care management team and provide information on community resources for patients regarding different chronic diseases. As a clinically integrated network (CIN), we are required to measure and report on the quality of care provided within the network. Three areas we are reporting on are diabetes mellitus, hypertension and hyperlipidemia.

Which patients should be referred to the program?

Our goal is to provide a patient-centered approach to disease management in coordination with physicians, care coordinators, clinical staff and operations staff. Please refer patients with uncontrolled diabetes – Hgb A1C of 9.0 and above.

How can each practice help ensure success for patients and the program?

1. Ensure you're performing the appropriate diabetes screening testing.
2. In the EHR, for newly diagnosed patients with an Hgb A1C of 9.0 and above, choose "Refer to Specialty" and specify the Diabetes Initiative.
3. Let your patient know that Care Coordinator Sandra Rapp, RN, CDE, CCM, will contact them to provide diabetes guidance and education (free to the patient).
4. Medical assistants can print the referral and submit to practice managers.
5. Practice managers should fax referrals to: 602-212-4841.
6. Confirm that your patient has a follow-up appointment and is seen every three months for appropriate follow-up and lab work.

Please note: This program is available to all patients except Medicare Advantage (Humana HMO/Gold, UHC Medicare Complete; Senior Dimensions are Care More). This population has its own programs and case managers.

BPCI Model 2 Update

At the recent SRQCN Board of Directors meeting, board members reviewed data on the Bundled Payments for Care Improvement (BPCI) program.

The most encouraging takeaway from this data was

1. the reduction of our inpatient rehabilitation facility (IRF) utilization by half compared with the baseline period; and
2. the decrease in the average length of stay for our skilled-nursing facilities by a full 12 days.

We also see areas where we can improve, such as by further reducing our IRF utilization and decreasing our long-term care hospital (LTCH) utilization, which rose slightly compared with other hospitals.

Our market as a whole has a much higher use of both IRF and LTCH than the Dignity Health hospitals.

Overall, there were 28 episodes at our three hospitals – 14 of which were positive and 14 of which were negative. Of those that were negative, 64 percent had an increase in at least one of the two factors, IRF or LTCH, from the baseline. Of those that were positive, 86 percent saw a decrease in both IRF and LTCH from the baseline.

If our three hospitals had IRF and LTCH utilization rates equal to that of the positive Dignity Health hospitals across all episodes, it is estimated that we could save more than $1.4 million to fund gainsharing.

A Quality 2.0 Primer

As the Dignity Health clinically integrated networks embrace our Quality 2.0 initiative, it's important to understand our current focus:

- Common scorecards for all physicians
- 34 quality measures across four domains (51 with MSSP)

The four domains we're focused on are:

Citizenship/Physician Engagement

- Measures the engagement level of individual physicians (and practices) in the CIN activities
- Examples include attending meetings, completing education and surveys, responsiveness to CM

Quality

- Measures effective care for prevention and at-risk population; some measures also reflect patient safety
- Examples include appropriate vaccinations, testing, management, appropriate medication use

Patient Experience

- Measures the experience of care as perceived by the patient +/- care giver, including ease of access to care
- Examples include patient education, direct measure of access or structure of clinic for expanded hours

Efficiency

- Measures the utilization of resources to identify potential overuse of services based on peer-reviewed evidence
- Examples include admissions per 1,000; ED visits per 1,000; and 30-day readmission rate

Clinical Pathways and Protocols

Over the past year, a group of physicians representing the clinically integrated networks (CINs) from across Dignity Health formed a Chronic Disease Management Task Force that focuses on creating evidence-based clinical pathways and protocols. The protocols are designed to assist with the outpatient management of chronic illnesses such as diabetes mellitus, hypertension, hyperlipidemia and COPD.

Each of these protocols has been approved by the SRQCN Quality Committee and Board of Managers. Their use is not mandatory; however, if your patient's clinical condition is out of control, the protocol may be a useful resource in guiding their care. We understand that there are many reasons why patients' clinical conditions may be out of control, and most importantly, we will rely on your good judgment to manage these difficult conditions.

Download and review the protocols for:

- Diabetes mellitus
- Hypertension
- Lipid management

The next clinical protocols in development will be COPD and opioid use.

The protocols are living documents, so if you have suggestions you'd like us to consider incorporating, please do not hesitate to contact us.

Participation Agreement Update

The SRQCN Board recently approved an update to the network participation agreement to include mid-level practitioners. We will begin adding mid-levels into the network membership, starting with ACO practices/groups.

If you have not already been contacted and would like to have your mid-levels under your TIN added to the network, please contact administration at **diana.diaz-pangilinan@dignityhealth.org**.

Opioid Task Force to Create an Ambulatory Opioid Pathway

Opioid prescribing and overuse has become a major public health issue in the United States. From 1999-2011, pain prescriptions quadrupled from 76 million to 219 million, including a nine-fold rise in oxycodone usage in roughly that same time span.

The United States consumes 83 percent of the world's oxycodone supply and 93 percent of the world's hydrocodone supply. In 2014 alone, there were 47,055 drug overdose deaths. The economic impact is also severe with $55 billion in health and social costs related to prescription opioid abuse each year and $20 billion in emergency department and inpatient care opioid poisonings.

Based on the growing public health issue associated with opioids, the Chronic Disease Management Workgroup has commissioned a special Opioid Task Force to create an appropriate ambulatory opioid pathway. As a result, a task force consisting of physicians representing regions across Dignity Health has been assembled to focus on the development of guidelines and controlled substance use agreements. They include:

- Greg Light, PharmD., Foundation
- Dr. Inna Zdorovyak, Nevada
- Dr. Ekaterina Pletinskaya, Nevada
- Dr. Robert Pretzlaff, Nevada
- Latricia Lacy, Nevada
- Dr. Elliott Meltzer, Santa Cruz
- Dr. Dean Kashino, Santa Cruz
- Dr. Chris Dunn, Sequoia
- Dr. Glenn Singer, Bakersfield
- Dr. Mike Swartout, Ventura
- Dr. Ed Paul, Arizona
- Dr. Gary Greensweig, Dignity Corporate
- Dr. Nicholas Stine, Dignity Corporate

Recognizing the vast pool of resources on the web and in clinical journals, the task force plans to utilize the established CDC recommendations and build from there. You can find those **recommendations for determining when to initiate or continue opioids for chronic pain here.** To this, they will add prescribing regulations relating to strength, quantities and duration. The task force hopes to finalize their recommendations by the end of the 2017 calendar year, and we will distribute those recommendations and controlled substance use agreements for your practices.

For anyone interested in learning more about the history of the opioid crisis in the United States, we highly recommend reading *Dreamland: The True Tale of America's Opiate Epidemic,* by Sam Quinones.

Physician Integration Update

New Direction for Clinical Steering Committee

In the late summer of 2016, the Southern California Quality Care Network-Ventura County, North State Quality Care Network and the St. Rose Quality Care Network in Las Vegas completed their Track 1 MSSP applications. By August of 2016 clinical planning had begun to answer this question: If we are approved by CMS to participate in the Medicare Shared Savings Program (MSSP), how would we take care of these patients? Our work started as the MSSP Clinical Steering Committee. We focused on three primary areas of activity:

- Practice transformation, including the emerging MIPS and MACRA programs, MSSP preparation and readiness, and clinical protocols
- Transitions in care and care coordination
- Community partnerships

The committee was composed primarily of the clinically integrated networks' (CINs) medical directors, executive directors and support staff, and we had a solid first year, successfully starting MSSP programs in the above three markets. We had certain challenges in Care Coordination planning and implementation and assuring that all of the MSSP providers knew what MSSP was about. A series of learning and communications tools were developed, including most notably the MIPS and MACRA Playbook, e-blasts about MSSP, and special communications for management and staff about MSSP.

One additional milestone was the inclusion of the Dignity Health Medical Foundation, including all of its medical groups – Mercy Medical Group, Woodland Medical Group, Santa Cruz Medical Group, and Foundation Physicians Medical Group in MSSP started at SCICN-Ventura County. With the Foundation's approximate 33,000 MSSP attributed lives, this brought the total attributed lives for the MSSP programs to approximately 52,000.

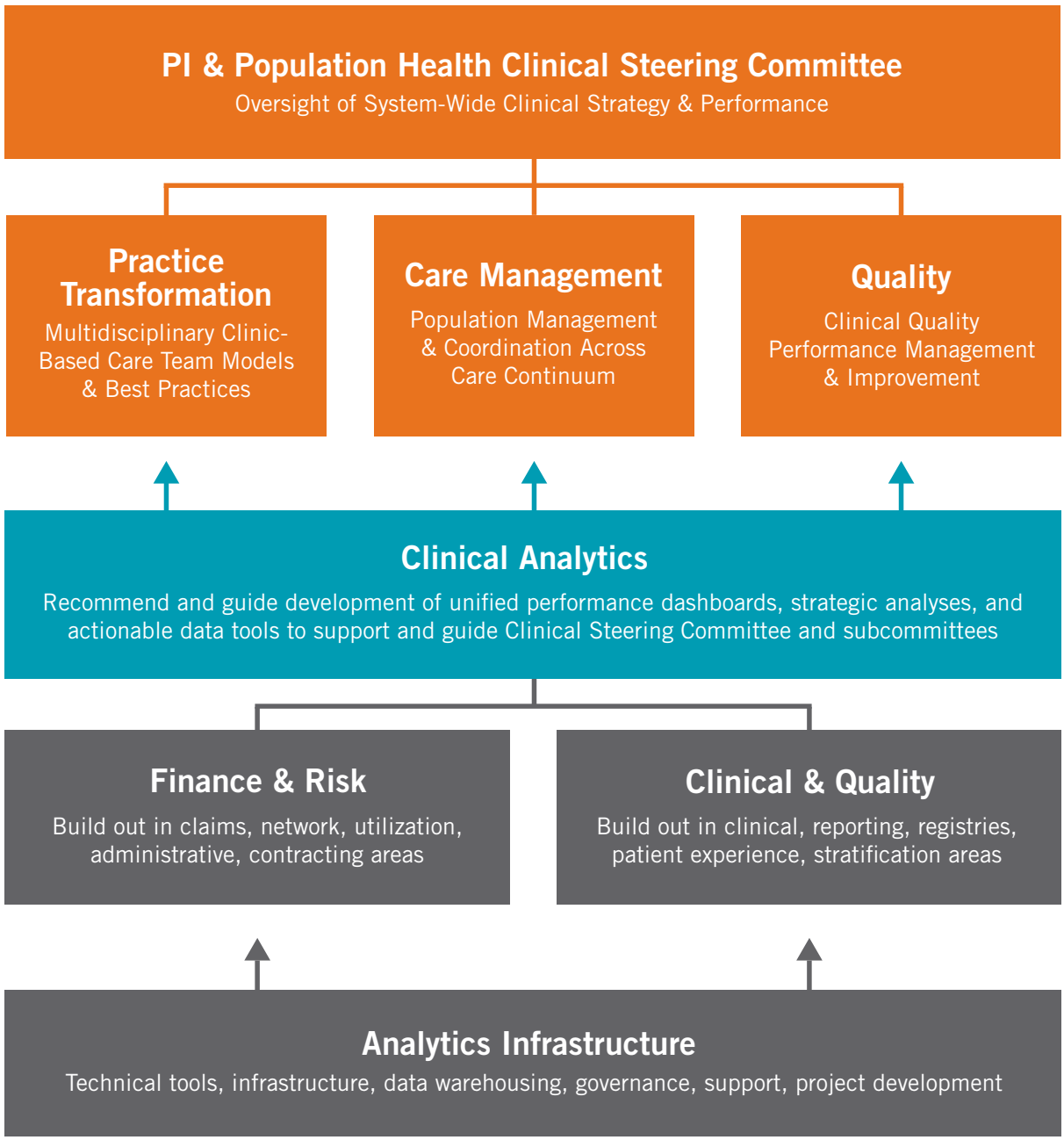
During the last several months we have worked to reformat the Clinical Steering Committee to be more inclusive of all of the MSSP and CIN physicians at Dignity Health. Our goal was to have one organizational structure that would be inclusive with physicians in the Foundation Medical Groups, Dignity Health Arizona Medical Group, the St. Rose Medical Group in Las Vegas and all of the independent physician members of our CINs. We hope to have one approach to the clinical management of patients in value-based agreements and population health across Dignity Health.

To that end, the Clinical Steering Committee has been expanded to include all of the stakeholders mentioned above. The Clinical Steering Committee will be supported by our Analytics Team and an Analytics Council. There will be three subcommittees with participant stakeholders from all of the groups mentioned above. These include:

- Practice transformation, including the development of clinical protocols
- Care coordination
- Quality measurement

(continued on page 10)

We believe that this expanded structure will help us provide organized, coordinated, excellent and data-driven care across all of Dignity Health. An organizational diagram of the newly designed clinical steering committee is below.



At this time the subcommittee chairpersons are working with their teams to create subcommittee charters, and a work plan for first-year deliverables. The Clinical Steering Committee will begin formal operations in October.

Sincerely,
Gary Greensweig, DO
Vice President & Chief Physician Executive for Physician Integration Dignity Health

Physician Leadership

Board of Managers
Irwin Simon, MD – Chair
Robert Gong, MD – Vice Chair
Anna Salcedo, MD – Secretary
Dara Welborn, MD
Scott Selco, MD
Troy Bertoli, MD
Shane Flaviano, MD
Rama Harouni, MD
Brian Lee, MD
Raji Venkat, MD

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

Finance Committee
Scott Selco, MD – Chair
Fred Herman, MD
Brian Lee, MD
Chandra Narala, MD
Matt Treinen, DO

Quality Committee
Robert Gong, MD – Chair
Dennis Chong, MD
Shane Flaviano, MD
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

SRQCN Leadership/Staff

Robert Pretzlaff, MD
Chief Physician Executive
702-616-5720

Margie Roper
VP Physician Integration & Ambulatory Operations
702-616-5720

Teresa Hong, MD
Medical Director
702-616-5761

Kalie Valencia
Director Physician Integration & Ambulatory Operations
702-616-5710

Ali Erosa, CMA, AAMA
Physician Practice Liaison
702-616-5717

Sandie Rapp, RN, CDE, CCM
RN Coordinator
702-616-5791

Tarra Cortez, BSN, RN, CCM
Clinical Practice Coordinator
702-616-5714

Jamee Gatchalian
Clinical Quality Navigator
702-616-5705

Diana Diaz-Pangilinan
Administrative Assistant
702-616-5761

Upcoming Events

Nov. 1 – Payer Committee
Nov. 9 – Board of Managers
Dec. 6 – Payer Committee
Dec. 14 – Board of Managers
Dec. 28 – Performance Evaluation

MSSP Learning Sessions
Nov. 10 – Lunch-n-Learn @ San Martin
Nov. 16 – Dinner-n-Learn @ Siena
Nov. 30 – Dinner-n-Learn @ San Martin
Dec. 7 – Breakfast-n-Learn @ Siena
Dec. 14 – Breakfast-n-Learn @ San Martin
Dec. 18 – Lunch-n-Learn @ Siena

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.

Welcome New SRQCN staff!
SRQCN would like to welcome the following new staff who joined us recently:

Jamee Gatchalian,
Clinical Quality Navigator

Jamee received her bachelor's degree in Healthcare Administration in 2015 and has since been with United Healthcare as a Field Intern, and HealthSouth Rehabilitation Hospital where she coordinated inpatient scheduling and assisted with case management. Jamee will work closely with our Quality Management Nurse to abstract specified clinical information and data to support compliance with network quality measures.