Medicare Shared Savings Program ACO Learning System

Strategies for CMS Quality Reporting and Improving Measure Performance

Thursday, October 26, 2017
2:30-4:00 PM ET

Audio for this session can be streamed through your computer, or accessed by phone by dialing 1-857-232-0156; access code: 271840
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Furthermore, to the extent that we may seek to gather facts and information from you during this call, we intend to gather your individual input. CMS is not seeking group advice.

To view a complete listing of past Shared Savings Program ACO Learning System activities, click on the Resource List widget at the bottom of the event console and navigate to the webinar index. This index is intended to help ACOs locate topic-specific events and provides a chronological, searchable list of Shared Savings Program activities available through the Learning System. The index also includes brief event descriptions, featured ACO speakers, and playback links to event recordings.
Webinar Agenda

• Housekeeping items
• Presentations:
  – Doctors ACO
  – Coastal Medical
  – Delaware Valley ACO
• Questions and answers
• Wrap-up
The widget menu located at the bottom of the event console contains various resources for the webcast. You can resize a widget by clicking on the maximize icon on the top right of the widget or dragging the bottom right corner of the widget panel.

**Q&A:** Pose questions to the presenters or submit technical questions.

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Doctors ACO

Amy Thompson
Provider Consultant
DOCTORS ACO, LLC

- Track 1, started in 2015
- Operating in GA, OH, IN, and FL
  - Coverage area(s): Rural, Urban, and Suburban
- Advance Payment or ACO Investment Model? NO
- Are any of the ACO participants hospitals? NO
- Number of practitioners: 90
- Number of assigned beneficiaries: ~11,000
- Percent EHR penetration, and number of EHR platforms used: 95% EHR penetration, ~12 platforms
ACO Formation, Culture and Background

- 100% Independent Providers; owned and operated by independent providers with a goal of helping others stay independent
- Most practices consist of a single provider or MD + NP
- Collaboration and sharing of knowledge within our group is encouraged and welcomed
Data Collection- 2015

- Each ACO practice was responsible for their own data collection on worksheets provided by the ACO
  - Clinic staff received basic training
- We relied almost exclusively on individual clinic’s records and did not seek reports/results from outside the clinic
- Not enough training on the measure specifics results in many “NO” answers
- We were simply UNDERPREPARED in our first year!
Data Collection- 2016 changes

- Same basic procedure but with MUCH MORE training for data collectors
- HAD WORKED ALL YEAR TO GET PRACTICES INVESTED IN QUALITY!
- For info not found in EHR, practices used their own records or our Medicare billing data to track down data from providers outside of the ACO
- “NO” answers had to be signed off on by provider
Before the Web Interface…

- Provided patient list and training on data gathering in December 2016 before WI opened in January for 2016 data entry
- All worksheets kept together in notebooks and checked every 2 weeks
  - This reduced chance of incomplete or misplaced worksheets
- DACO staff entered into Web Interface, auditing worksheets as they entered
Web Interface Lessons

- Did not start data collection until WI opened in Year 1 (2015)
- Started much earlier in Year 2 (2016)
  - Patient lists given to clinics as soon as available
  - Training before first of the year
- All “No” answers had to be run by provider before entered into WI
  - This helped make providers aware of areas that needed improvements for following year
“Stay organized, provide helpful tools, and give specific, repetitive training!”

OUR MANTRA
Since practice managers/staff were the main collectors of data, we did in-person training individually with EVERYONE in December/January to prepare for 2016 data collection.

DACO staff were the only ones to enter into Web Interface to reduce entry errors.

“Old School” chart audits combined with claims data to identify additional providers who may have additional information.

For 2017 reporting, plan to present and record a webinar for training that all practices can watch anytime they need a refresher.

Also encouraging enhanced usage of EHR Dashboards to speed up the collection process in 2017.
<table>
<thead>
<tr>
<th>Name Brand</th>
<th>Generic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biodemid</td>
<td>Timolol</td>
</tr>
<tr>
<td>Cartol</td>
<td>Carvediol</td>
</tr>
<tr>
<td>Coreg CR</td>
<td>Carvediol E/R</td>
</tr>
<tr>
<td>Carper</td>
<td>Nadolol</td>
</tr>
<tr>
<td>Cartilol</td>
<td>Carvediol</td>
</tr>
<tr>
<td>Corez</td>
<td>Bendrofluamide / Nadolol</td>
</tr>
<tr>
<td>Dutro, Loressor HCT</td>
<td>Hydrochlorothiazide / Metoprolol</td>
</tr>
<tr>
<td>Inderal, Inderal, Inderal XL, Ilopro, Ilopr XL</td>
<td>Propranolol</td>
</tr>
<tr>
<td>Inderal LA</td>
<td>24 HR Propranolol Hydrochlorothiazide Extended Release Capsule</td>
</tr>
<tr>
<td>Inderide</td>
<td>Hydrochlorothiazide / Propranolol</td>
</tr>
<tr>
<td>Kerone</td>
<td>Betaxolol</td>
</tr>
<tr>
<td>Lopress, Toprol</td>
<td>Metoprolol</td>
</tr>
<tr>
<td>Normodyne, Tranlate</td>
<td>Labetalol</td>
</tr>
<tr>
<td>Normoxide</td>
<td>Labetalol/Hydrochlorothiazide</td>
</tr>
<tr>
<td>Secrectal</td>
<td>Atenolol</td>
</tr>
<tr>
<td>Seltzale</td>
<td>Atenolol/Hydrochlorothiazide</td>
</tr>
<tr>
<td>Tenoretic</td>
<td>Atenolol / Chlorthalidone</td>
</tr>
<tr>
<td>Timolide</td>
<td>Timolol/Hydrochlorothiazide</td>
</tr>
<tr>
<td>Toprol XL</td>
<td>24 HR Metoprolol Tartrate</td>
</tr>
<tr>
<td>Viskalixid</td>
<td>Clopamide / Pindolol</td>
</tr>
<tr>
<td>Viskicide</td>
<td>Pindolol/Hydrochlorothiazide</td>
</tr>
<tr>
<td>Viskol</td>
<td>Pindolol</td>
</tr>
<tr>
<td>Zebeta</td>
<td>Bisoprolol</td>
</tr>
<tr>
<td>Ziac</td>
<td>Bisoprolol/Hydrochlorothiazide</td>
</tr>
</tbody>
</table>

This list of Beta-Blocker medications is all-inclusive.

<table>
<thead>
<tr>
<th>Name Brand</th>
<th>Generic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Etoxarin, Bayver</td>
<td>Aspirin</td>
</tr>
<tr>
<td>Aggrenox</td>
<td>Combo of Aspirin &amp; ER Dipyridamole</td>
</tr>
<tr>
<td>Flavix</td>
<td>Clopidogrel</td>
</tr>
<tr>
<td>Effient</td>
<td>Prasugrel</td>
</tr>
<tr>
<td>Brilinta</td>
<td>Ticagrelor</td>
</tr>
<tr>
<td>Ticlid</td>
<td>Ticlopidine</td>
</tr>
</tbody>
</table>

This list of Antithrombotic medications is all-inclusive.

**Diagnoses to accompany IVD-2, CAD-7, and PREV-13 for GPRO 2016**

**IVD-2: Ischemic Vascular Disease (IVD)**
Patients where were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in 2015 or 2016 should be included in the measure.

- Atherosclerosis with angina (chest pain due to CAD or valvular disease)
- Atherosclerosis of native coronary artery or arteries of extremities
- Stroke (CVA) or transient ischemic attack (TIA) due to ASCVD in 2015 or 2016
- Claudication
- Ischemic cardiomyopathy
- Acute or chronic ischemic heart disease
- Acute coronary thrombosis
- Occlusion and stenosis of cerebral, carotid, or vertebral arteries
- Embolism and thrombosis of abdominal aorta or other arteries

*The diagnosis of Peripheral Vascular Disease (PVD) and/or Peripheral Arterial Disease (PAD) would not be considered confirmation of a diagnosis of IVD.*

**CAD-7: Coronary Artery Disease**
Patient must have an active diagnosis of CAD or history of cardiac surgery at any time up through the last day of 2016.

- Angina pectoris (chest pain alone is not enough, must have additional indications of CAD)
- Acute ischemic heart disease
- Myocardial infarction (MI) (recent or history of)
- Atherosclerotic heart disease
- Atherosclerosis of any coronary artery
- Myocardial ischemia
- Chronic ischemic heart disease
- Presence of aortocoronary bypass graft or coronary angioplasty implant and graft
### Data Collection Worksheets

<table>
<thead>
<tr>
<th>Rank care 3</th>
<th>284</th>
<th>Confirmed: Yes/No</th>
<th>Not Confirmed-Age/Not Confirmed No Qualifying Visits</th>
<th>Date:</th>
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<tbody>
<tr>
<td>OV Date 1</td>
<td>01/20/2016</td>
<td>Pt Seen?</td>
<td>Yes/No</td>
<td>Meds Doc/Update/Review?</td>
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<td>OV Date 2</td>
<td>02/16/2016</td>
<td>Pt Seen?</td>
<td>Yes/No</td>
<td>Meds Doc/Update/Review?</td>
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<td>OV Date 3</td>
<td>04/11/2016</td>
<td>Pt Seen?</td>
<td>Yes/No</td>
<td>Meds Doc/Update/Review?</td>
</tr>
<tr>
<td>OV Date 4</td>
<td>06/18/2016</td>
<td>Pt Seen?</td>
<td>Yes/No</td>
<td>Meds Doc/Update/Review?</td>
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<tr>
<td>OV Date 5</td>
<td>08/16/2016</td>
<td>Pt Seen?</td>
<td>Yes/No</td>
<td>Meds Doc/Update/Review?</td>
</tr>
<tr>
<td>OV Date 6</td>
<td>10/17/2016</td>
<td>Pt Seen?</td>
<td>Yes/No</td>
<td>Meds Doc/Update/Review?</td>
</tr>
<tr>
<td>OV Date 7</td>
<td>12/15/2016</td>
<td>Pt Seen?</td>
<td>Yes/No</td>
<td>Meds Doc/Update/Review?</td>
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<tr>
<td>OV Date 8</td>
<td>01/20/2017</td>
<td>Pt Seen?</td>
<td>Yes/No</td>
<td>Meds Doc/Update/Review?</td>
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<tr>
<td>OV Date 9</td>
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<td>Yes/No</td>
<td>Meds Doc/Update/Review?</td>
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<td>OV Date 10</td>
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<td>Yes/No</td>
<td>Meds Doc/Update/Review?</td>
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<tr>
<td>OV Date 11</td>
<td>06/18/2017</td>
<td>Pt Seen?</td>
<td>Yes/No</td>
<td>Meds Doc/Update/Review?</td>
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<tr>
<td>OV Date 12</td>
<td>08/16/2017</td>
<td>Pt Seen?</td>
<td>Yes/No</td>
<td>Meds Doc/Update/Review?</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Rank care 2</th>
<th>222</th>
<th>Confirmed: Yes/No</th>
<th>Other CMS Reason</th>
<th>Screen Fall Risk: Yes/No/No-Medical Reasons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rank cad</td>
<td>CAD Confirmed</td>
<td>Yes/Not Confirmed-Diagnosis/No-Other CMS Reason</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has DM or LVSD</td>
<td>Yes/No</td>
<td>Has ACE-I/ARB</td>
<td>Yes / No / No-Med Reasons / No-Pt Reasons / No-System Reasons</td>
<td></td>
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<tr>
<td>Rank dm</td>
<td>DM Confirmed</td>
<td>Yes/Not Confirmed-Dx/No-Other CMS Reason</td>
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<td>HBA1c Test</td>
<td>Yes/No</td>
<td>Blood Draw Date:</td>
<td>HBA1c Value (0.00-25.99):</td>
<td>DM Eye Exam?</td>
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<tr>
<td>Rank hf</td>
<td>HF Confirmed</td>
<td>Yes / Not Confirmed-Dx / No-Other CMS Approved Reason</td>
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<td></td>
</tr>
<tr>
<td>Has LVSD</td>
<td>Yes/No</td>
<td>Beta Blocker</td>
<td>Yes / No / No-Medical / No-Patient / No-System</td>
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</tbody>
</table>
Improving Quality Measure Performance

We improved in the majority of Quality Measures from Year 1 (2015) to Year 2 (2016) due to the following factors:

1) Creation of comprehensive Medicare Annual Wellness Visit template that all practices were encouraged to use
2) More emphasis on AWV for ALL Medicare patients
3) Better training on what measures were included in Quality Reporting and reminders throughout the year
4) More provider emphasis on Preventive Health
Improving Quality Measure Performance

- In particular, Fall Risk Screening, Depression Screening, and Diabetic Eye Exams all improved dramatically due to more emphasis throughout the year and more thorough collection at GPRO time.
  - Some clinic began doing in-clinic retinal exams

- Practices were EXPECTED to track down reports that were not already in the EHR (i.e. mammograms, diabetic eye exams, etc. conducted outside the clinic)
And... It Worked!

2016 Quality Performance Summary

<table>
<thead>
<tr>
<th>Domain</th>
<th>Points Earned without Quality Improvement Points</th>
<th>Quality Improvement Points</th>
<th>Points Earned with Quality Improvement Points</th>
<th>Domain Score</th>
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</thead>
<tbody>
<tr>
<td>Patient/Caregiver Experience</td>
<td>15.10</td>
<td>0.92</td>
<td>16.00</td>
<td>100.00%</td>
</tr>
<tr>
<td>Care Coordination/Patient Safety</td>
<td>20.35</td>
<td>2.24</td>
<td>22.00</td>
<td>100.00%</td>
</tr>
<tr>
<td>Preventive Health</td>
<td>16.80</td>
<td>3.56</td>
<td>18.00</td>
<td>100.00%</td>
</tr>
<tr>
<td>At Risk Population</td>
<td>11.70</td>
<td>1.36</td>
<td>12.00</td>
<td>100.00%</td>
</tr>
<tr>
<td>Measure Name</td>
<td>Performance Rate - 2015</td>
<td>Performance Rate - 2016</td>
<td>Mean Performance Rate (SSP ACOs)</td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
<td>-------------------------</td>
<td>--------------------------</td>
<td>----------------------------------</td>
<td></td>
</tr>
<tr>
<td>Documentation of Current Medications in the Medical Record</td>
<td>93.31%</td>
<td>95.44%</td>
<td>87.54%</td>
<td></td>
</tr>
<tr>
<td>Falls: Screening for Future Fall Risk</td>
<td><strong>47.91%</strong></td>
<td><strong>69.33%</strong></td>
<td>64.04%</td>
<td></td>
</tr>
<tr>
<td>Preventive Care and Screening: Influenza Immunization</td>
<td>61.68%</td>
<td>73.77%</td>
<td>68.32%</td>
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</tr>
<tr>
<td>Pneumonia Vaccination Status for Older Adults</td>
<td><strong>48.42%</strong></td>
<td><strong>60.13%</strong></td>
<td>69.21%</td>
<td></td>
</tr>
<tr>
<td>Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up</td>
<td><strong>79.80%</strong></td>
<td><strong>90.15%</strong></td>
<td>74.45%</td>
<td></td>
</tr>
<tr>
<td>Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention</td>
<td>95.54%</td>
<td>95.97%</td>
<td>90.98%</td>
<td></td>
</tr>
<tr>
<td>Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan</td>
<td><strong>32.62%</strong></td>
<td><strong>66.27%</strong></td>
<td>53.63%</td>
<td></td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td><strong>49.83%</strong></td>
<td><strong>60.42%</strong></td>
<td>61.52%</td>
<td></td>
</tr>
<tr>
<td>Breast Cancer Screening</td>
<td>54.64%</td>
<td>62.99%</td>
<td>67.61%</td>
<td></td>
</tr>
<tr>
<td>Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented</td>
<td>85.46%</td>
<td>95.59%</td>
<td>76.79%</td>
<td></td>
</tr>
<tr>
<td>Depression Remission at Twelve Months</td>
<td>0.00%</td>
<td>17.65%</td>
<td>6.40%</td>
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</tr>
<tr>
<td>Diabetes Composite (All or Nothing Scoring)</td>
<td><strong>24.13%</strong></td>
<td><strong>41.14%</strong></td>
<td>39.31%</td>
<td></td>
</tr>
<tr>
<td>Diabetes Mellitus: Hemoglobin A1c Poor Control</td>
<td>20.81%</td>
<td>18.33%</td>
<td>18.24%</td>
<td></td>
</tr>
<tr>
<td>Diabetes: Eye Exam</td>
<td><strong>27.81%</strong></td>
<td><strong>46.64%</strong></td>
<td>44.94%</td>
<td></td>
</tr>
<tr>
<td>Hypertension: Controlling High Blood Pressure</td>
<td>65.24%</td>
<td>70.50%</td>
<td>70.69%</td>
<td></td>
</tr>
<tr>
<td>Ischemic Vascular Disease: Use of Aspirin or Another Antithrombotic</td>
<td>90.66%</td>
<td>90.95%</td>
<td>85.05%</td>
<td></td>
</tr>
<tr>
<td>Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)</td>
<td>95.71%</td>
<td>96.72%</td>
<td>88.67%</td>
<td></td>
</tr>
<tr>
<td>Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy - for patients with CAD and Diabetes or Left Ventricular Systolic Dysfunction (LVEF&lt;40%)</td>
<td>83.23%</td>
<td>86.52%</td>
<td>79.67%</td>
<td></td>
</tr>
</tbody>
</table>
Strategies & Lessons Learned

- Biggest lesson learned was that, if asking practices to gather their own data, start early and check in often! Stress the “audit-proof” collection process.
- Easy-to-understand tools help make data collection quicker and more accurate. Assume an MA, biller, or someone without extensive medical training is collecting the data and tailor your tools to them.
- Utilize Custom Exceptions
Pearls of Wisdom

Again, our mantra:

Stay organized, provide helpful tools, and give specific, repetitive training!
Contact Information

Amy Thompson, Director and Provider Consultant
Doctors ACO – Athens, GA
athompson@doctorsaco.org

DoctorsACO.org
Questions & Answers

• Please submit questions through the Q&A panel/widget
Coastal Medical

Marilyn Boichat
Director of Practice Management

Aleah George
Senior Data Analyst
MSSP Learning System Webinar

Aleah George
Senior Data Analyst

Marilyn Boichat, RN
Director of Practice Management

October 26, 2017
Coastal Medical

- Started in Track 1, July 2012 | 2016 Renewal
- State: Rhode Island
- Advance Payment Model
- Primary Care, provider-based ACO
  - No participating hospitals
- Urban/Suburban
- Number of clinicians: 134
- Number of assigned beneficiaries: 10,700
- 1 EHR (eClinicalWorks), 100% penetration
ACO Background

- Patient Centered Medical Home as foundation
- Pay-for-performance on quality since 2007
- Triple Aim deeply resonated with shared values
- Advance Payment Model enabled infrastructure investment
- Six ACO/Shared Savings Contracts
  - ~75% of Coastal patients under ACO payment model
Analytic Resources

- Analytics Team & Tools
  - CIO, Data Analytics Manager & 4 Analysts
  - Custom built reports for data extraction: Cognos Platform and SQL

- EHR: Utilize templates, flowsheets and care alerts

- Data from non-ACO sources:
  - State Health Information Exchange (HIE)
  - Remote access to hospital EHR
  - Reporting from high volume specialty groups
Centralized Quality Team

- Coastal Core
  - Standardized workflows for every quality measure
- Optimize structured data fields in EHR to create standard documentation
- Personnel
  - Director of Practice Management
  - Office-based Medical Assistants
  - Centralized Quality & Document Management Teams
Web Interface Reporting Timeline

- **Year-round**: Monthly Quality Reporting
- **Q4 of PY**: Quality Season: The Final Push
- **Jan - Mar**: Go Time! Web Interface Submission
## Web Interface Reporting Timeline

<table>
<thead>
<tr>
<th>Year-round</th>
<th>Monthly Quality Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Thorough specification review and updates</td>
<td></td>
</tr>
<tr>
<td>• Standardized quality performance report delivered to all practices</td>
<td></td>
</tr>
<tr>
<td>• Exception reports: Identify patients with gaps in care by measure</td>
<td></td>
</tr>
<tr>
<td>• Regular site visits to practices</td>
<td></td>
</tr>
</tbody>
</table>

### Q4 of PY  Quality Season: The Final Push |
| • Transition to payer-specific performance |
| • Goal = Close all care gaps |
Web Interface Reporting Timeline

Jan - Mar

Go Time! Web Interface Submission

- Match ranked beneficiaries to EHR (~20 Hours)
- Opening of Web Interface
  - Validate data extraction and measure performance
  - XML formatting for data upload to the Web Interface
  - ~25 hours/week for 4 weeks (~100 hours)
- Total GPRO Reporting time of approximately 250 hours
  - Does not include ongoing daily efforts of quality assistants and office staff
Improving Quality Measures

Improving Performance on Eye Exam for Patients with Diabetes

- Ordering
- Scheduling
- Tracking
Improving Quality Measures

...Is Still Challenging

Depression Screening and Remission

- Challenges: Narrow timeframe for re-screening
- Strategy: Centralized telephonic screenings to offload clinicians
- Continued Struggle: Difficult to Scale
  - Screening by Medical Assistants with close clinician supervision
Strategy & Lessons

- Strategy = Standardize quality measure workflows
- Lessons
  - Success requires continuous monitoring of measure performance
  - Office site visits are essential
  - Standardized workflows are the keys to success
Contact Information

Aleah George
Senior Clinical Quality Data Analyst
ageorge@coastalmedical.com

Marilyn Boichat
Director of Practice Management
mboichat@coastalmedical.com
Questions & Answers

• Please submit questions through the Q&A panel/widget
Delaware Valley ACO

Virginia Bodycot
Director, Quality Improvement

Dr. Mitch Kaminski
Chief Clinical Officer
Delaware Valley ACO

- A Track1 MSSP ACO in our fourth year of operation (2014, renewed 2017)
- Serving 85,000 Medicare beneficiaries in the Greater Philadelphia region
- Two large health system partners: Jefferson Health System and Main Line Health
- 650 primary care physicians in 250 primary care practices, 2000+ specialists
- EMR and PCMH recognition required for PCP membership
- ~2/3 employed PCPs, 1/3 independent
- ~15 total EMRs; Epic implementation underway for two largest groups
ACO Formation, Culture and Background

- DVACO formed in 2014, health system sponsored with physician leadership

- Rapid growth created administrative reporting challenges (new practice members)
  - 2014-2015 30,000 → 65,000 MSSP
  - 2015-2016 65,000 → 125,000
  - 2016-2017 125,000 → 85,000 (two smaller health systems left, formed a smaller ACO)

- In 2017, three commercial shared savings contracts with additional 100,000 members
DVACO Web Interface Reporting Overhaul

- CMS Audit in PY2015 - Caused a total review and re-tool of abstraction activities
  - More investment and collaboration with our physician partners and their staff
  - Focus on education
  - Focus on internal QI
  - Utilize all the resources from CMS (webinars, help-desk, website, etc.)
Project Management and Timeline

DVACO Year-Round Web Interface Activities

- **DVACO Quality Improvement Activities**
  - January-March Quality Improvement Activities
    - Daily Huddles with DVACO GPRO Operations /Tech
    - Weekly Vendor Call
    - Weekly Creation/Distribution of GPRO “News you Can Use” Newsletter
    - Daily Open Phone lines for Questions from abstractors
    - Weekly QI Leadership Meetings (Representatives from each DVACO Physician Owned Distributorship(POD))
    - Weekly CMS Q&A Calls

- **Report Creation/Analysis Activities from Previous Performance Year**
  - Internal Lessons Learned for Previous Abstraction activities
  - Operational Planning and Coordination Begins For Abstraction (Staffing/Education, etc.)

- **Performance Year Ends**

- **Submission to CMS**

- **Performance Year Begins**
  - January
  - February
  - March
  - April
  - May
  - June
  - July
  - August
  - September
  - October
  - November
  - December
Multiple Source Abstraction Challenges

Abstraction Strategy

• Stratify CMS sample to abstract from PCP first

• Utilize reports to identify specific claims that lead to locations of needed information
  ▪ “Meet and Greets” with organizations
  ▪ Education regarding measures
  ▪ Identify and resolve
Abstraction Challenges (cont’d)

- Multiple EMRs Strategy/Challenges
  - DVACO currently has ~15 EMRs used by providers
    - Knowledge gap regarding what can be produced from various EMRs
    - Lack of standardized documentation
    - Structured fields vary within each EMR
  - Utilize Technology
    - Reporting from EMR when able
    - Remote abstraction
Abstraction Education

- Identify and implement “Lessons Learned”
- Identify source of
- Reduce variability - limit those who abstract
- Develop “goof-proof” guides, aides
- Try to move Physician office staff to a “consulting role”
- Offer assistance of a Subject Matter Expert (SME) to abstractors
- Create a culture of “permission” to what is not known
  - Eliminate barriers that cause abstractor not to ask for help
DVACO MSSP Quality Measures Flowchart
GPRO PREV-8 (NQF 0043): Pneumonia Vaccination Status for Older Adults

Review Medical Record for eligible patient (Age 65 and older by January 1, 2017 with a visit between Jan. 1, 2017- Dec.31, 2017)

Is there documentation in the medical record that the patient has ever received a pneumococcal vaccination (Prevnar-13 or Pneumovax)? Can be documented as patient reported.

YES

Document “YES” Record vaccine type and the Date in MM/DD/YYYY format. For vaccines given before Jan.1, 2015, document year only. Stop Abstraction

NO

Document “NO” Stop Abstraction
Abstraction Staffing and Support

- Abstraction Staffing
  - Utilize non-clinical and clinical staff (coordinate with partners) – 33 abstractors (not all abstractors are full time)
    - Hospital medical records and quality staff, clinical nurses, DVACO Practice Transformation staff, Care Coordinators
    - Temporary RN from DVACO - educated by DVACO
    - Internal QA of abstraction information
    - Use office staff in “consulting” role
  - All abstractors educated together (webinar)

- Submission/Abstraction Support
  - Full Time - DVACO Quality Improvement Director and Web Interface Coord.
  - Full time - Temporary Administrative Support during abstraction
  - Project Manager – Web Interface work priority
  - Data Analysts - Web Interface work priority
  - DVACO Leadership (clinical/operational/administrative) – all Web Interface asks considered priority
  - Vendor for abstraction (tool) and support/reporting
2017 GPRO News You Can Use!
Published by the DVACO Quality Improvement Department

INSIDE THIS ISSUE:
- GPRO 2017 Begins
- Rating File Received from CMS
- GPRO File Facts
- New This Week

2017 Annual Quality Submission for PY2016 Begins!

The purpose of this short weekly newsletter is to provide specialized information to our POD partners regarding the 2017 GPRO submission. Each week, you will receive a short update with important information that tracks and communicates our progress with the DVACO Annual Quality Submission to CMS.

GPRO File Facts:
- CMS has given DVACO over XXXX patients available for abstraction
- Patient files include a total of XXXXXXX measures (XXX patients per measure)
- DCACO must confirm and submit information for XXX measures

DVACO Receives Ranking File from CMS

On January 4, DVACO successfully received its patient sample (Patient Ranking File) electronically from CMS.

DVACO has been in contact with offices and coordinated abstraction activities for 2017.

New This Week:
- DVACO held the first of two live GPRO measure education webinars on January 3. The next webinar will be held on January 5. All webinars were recorded and are available to abstractors. Abstractors are required to complete and pass a post-test after the webinar sessions before abstracting activities begin.

Feel free to direct questions or comments to:
Ginia Boddie RN, DVACO Director, Quality Improvement,
boddieno@dvaco.org or call 010-225-0242
Improving Quality across the Continuum

- **Post Abstraction Activities**
  - Document questions, lessons, information etc. during the abstraction time period
  - Lessons Learned meetings annually post abstraction with entire team
    - Basis for improvement processes for the following year
  - Analysis of Abstraction Results based on CMS and internal reports

- **Quality Improvement**
  - Quality Improvement goals and activities - developed and designed based on data, results and organizational goals

- **Outcomes Success for PY2016**
  - DVACO demonstrated significant improvement in the following measures/domains: Falls Risk Screening, most Preventative Health Measures, Controlling High Blood Pressure, Use of Aspirin and other Antithrombotic
Highlights of Improvement Activities during 2016 (not all inclusive)

- Screening for Future Falls Risk
  - Broad education of measure to provider, office support staff
  - Targeted education
  - Ongoing education of measure – some EMR use education

- Screening for Clinical Depression and Follow-up
  - Broad education of measure to provider, office support staff and DVACO staff
  - Survey to all Offices
  - Re-education with specifics based on survey results
  - Specific education and custom process development
  - Clinical leadership
  - Ongoing measurement
DVACO Future Strategies

- Strategic Population Health Data analysis
- Closing Gaps
  - Expand the role of Care Coordination to drive certain measures
  - Stand up a DVACO Outreach Team
  - Consider the use of available technology/mail (multi-channel engagement to close gaps)
  - Consider the utilization of Telehealth
- Practice Transformation Team continues to be the “feet on the street”
  - Relationship Building and Education
- Process Improvement
  - Education
  - Implementation
DVACO Lessons Learned

- Multiple EMRs will always complicate the process
- Education at all levels - most important
- Reduce variation as much as possible (reduce the number of abstractors)
- Vendor selection and support
- Integrated data analysis
- Targeted quality improvement activities

Pearl of Wisdom -
CMS Annual Quality Reporting is a year round activity!
Contact Information

- **Mitchell Kaminski, MD, MBA**
  
  Chief Clinical Officer  
  Delaware Valley ACO  
  259 N. Radnor-Chester Road, Suite 290  
  Radnor, PA 19087  
  (610) 225-6226  
  KaminskiM@MLHS.ORG

- **Ginna Bodycot, BSN, RN**
  
  Director, Quality Improvement  
  Delaware Valley ACO  
  259 N. Radnor-Chester Road, Suite 290  
  Radnor, PA 19087  
  (610) 225-6242  
  BodycotV@MLHS.ORG
Questions & Answers

• Please submit questions through the Q&A panel/widget
Please give us your feedback!

- Open the survey widget located in the widget menu at the bottom of your event console.
- Don’t forget to press the submit button when finished!
Thank you!

- Slides and a link to the webinar recording will be posted to the ACO portlet. A recording will also be available tomorrow from the audience link that you used to attend.
- Please complete the webinar evaluation.
- Fee free to send questions, comments, and suggestions for future topics to ACOLearningActivities@mathematica-mpr.com