Paul Rosen, MD
Medical Officer

Centers for Medicare & Medicaid Services
The Importance of Transformation

Jami Snyder
Director

Arizona Health Care Cost Containment System (AHCCCS)
The Importance of Integrated Care

Kim Salamone
Vice President
Health Services Advisory Group (HSAG)
Transforming a Slice of Pii

Kim Salamone, PhD
Vice President, Health Information Technology
Health Services Advisory Group (HSAG)
September 16, 2019

Pii = Practice innovation institute
Disclosure

• I have nothing to report, nor are there any real or perceived conflicts of interest, implied or expressed, in the following presentation.

Kim Salamone, PhD
HSAG as Technical Assistance Contractor, Pt. 1

Medicaid’s External Quality Review Organization (EQRO)
- EQRO-related services in 17 states
- Serves as the designated EQRO in 16 states
- Comprehensive Primary Care End-Stage Renal Disease (ESRD)
  - Quality improvement technical assistance (TA)
  - Data management
  - Grievance investigation
  - Education services for Networks 7, 13, 15, and 17

Hospital Improvement Innovation Network (HIIN)
- Antibiotic stewardship
- Sepsis
- Adverse Drug Events, etc.
Quality Payment Program (QPP)
- Small, Underserved, Rural (SURS)
- Large: More than 16 eligible clinicians in a practice

Through the Quality Innovation Network-Quality Improvement Organization (QIN-QIO)
- Physician office (Million Hearts®, immunizations, behavioral health)
- Care transitions (hospitals, physicians, nursing homes)
- Hospitals (hospital-acquired infections, value-based purchasing)
- Nursing home (Healthcare-acquired conditions, antipsychotic medications)
Agenda

Celebrate Practice Innovation Institute (Pii’s) success stories and performance

The future of healthcare technology
- 21st Century Cures Act
- Interoperability
- Fast Healthcare Interoperability Resources (FHIR)
- Application programming interfaces (APIs)
- Blockchain
- Health Information Exchange (HIEs); Health Current
- Artificial or augmented intelligence

Alternative Payment Models (APMs)
Pii

Success Stories
Pii practices and participants
• Onboarded to Health Current for health information exchange
• Began using direct email
• Implemented workflow related to ADT Alerts

ADT = Admission Discharge Transfer
Practice Success Stories

Pii practices and participants
• Harmonized quality improvement efforts
  • CMS Quality Payment Program – Merit-based Incentive Payment System (MIPS)
  • AHCCCS – Targeted investment program
  • Health Resources and Services Administration (HRSA) – Uniform data system reporting
• Practice strategic goals

CMS = The Centers for Medicare & Medicaid Services
AHCCCS = Arizona Health Care Cost Containment System
PII Medication Management and Opioid Initiative

- Practice visits
  - Epidemic overview
  - Prescriber CMS requirements and training opportunities
  - Medication Management and Opioid Initiative Pledge
  - Arizona initiatives such as syringe access programs, naloxone kits, Arizona Department of Health Services (ADHS) standing prescription order
- Practice staff trainings by request
- “Prescription for Change” Opioid Conference, August 24, 2019
Transforming Clinical Practice Initiative’s (TCPI’s) Importance

Why Is Transformation So Important?
“Transformation” and “Interoperability”

- Physician Quality Reporting System (PQRS) and the Sustainable Growth Rate (SGR)
- Public Health Service Act
  - Established electronic health record (EHR) certification program
- Accountable Care Act
  - Health Information Technology for Economic and Clinical Health (HITECH) Act
    - EHR Incentive Program
- Medicare Access and CHIP (Children’s Health Insurance Plan) Reauthorization Act of 2015 (MACRA)
  - Married PQRS and Meaningful Use in the Quality Payment Program (QPP)
  - Established Advanced Alternative Payment Models
- 21st Century Cures Act, enacted in December 2016
  - Certified EHR technology (CEHRT) developers to publish application programming interfaces (APIs)
  - Develop a Trusted Exchange Network that includes a common agreement among health information networks
  - Interoperability and Patient Access Proposed Rule – This addresses the use and applicability of APIs and fast healthcare Interoperability Resources (FHIR).
The Future of Healthcare and Technology
The Future of Healthcare Technology

- 21st Century Cures Act
- Interoperability
- FHIR
- APIs
- Blockchain
- HIEs (Health Current)
- Artificial or augmented intelligence
History of the 21st Century Cures Act

January 6, 2015
Introduced in the U.S. House of Representatives

October 6, 2015
Passed/Agreed to in the Senate with an amendment

December 7, 2016
Senate agreed to the House amendment to the Senate Amendment

December 13, 2016
Signed by the President into public law

January 7, 2015
Passed/Agreed to in the House

November 30, 2016
House agreed with an amendment

December 8, 2016
Presented to the President

21st Century Cures Act, Pt. 1

• Title IV – Delivery
  – Sec. 4001. Assisting doctors and hospitals in improving quality of care for patients.
  – Sec. 4002. Transparent reporting on usability, security, and functionality.
  – Sec. 4003. Interoperability.
  – Sec. 4004. Information blocking.
  – Sec. 4005. Leveraging electronic health records to improve patient care.
  – Sec. 4006. Empowering patients and improving patient access to their electronic health information.
  – Sec. 4007. GAO study on patient matching.
  – Sec. 4008. GAO study on patient access to health information.
  – Sec. 4009. Improving Medicare local coverage determinations.
  – Sec. 4010. Medicare pharmaceutical and technology ombudsman.
  – Sec. 4011. Medicare site-of-service price transparency.
  – Sec. 4012. Telehealth services in Medicare.

GAO = General Office of Accounting

Section 4002

Transparent Reporting

- As a condition of CHPL certification and maintenance of certification, the HIT developer or entity “does not take any action that constitutes information blocking” or “any other action that may inhibit the appropriate exchange, access, and use of electronic health information”
- A healthcare provider whose adopted health IT is decertified is exempted from the application of a payment adjustment
- HHS must support the convening of stakeholders to develop reporting criteria

Section 4003

Interoperability defined

- The term ‘interoperability,’ with respect to health information technology, means that it...
  - enables the secure exchange of EHR with other health information technology without special effort on the part of the user;
  - allows for complete access, exchange, and use of all electronically accessible health information and
  - does not constitute information blocking
On January 2018, the ONC released the Trusted Exchange Framework (TEF) Draft 1.

On April 2019, the ONC released a modified draft broken into three parts:
- The TEF Draft 2
- The Minimum Required Terms and Conditions (MRTCs) Draft 2
Recognized Coordinating Entity (RCE)

- Structure
- Health Information Networks (HINs)
- Health Information Exchanges (HIEs)
- Individuals
- Providers
- Federal agencies
- Public health agencies…

Interoperability

Simply put: The meaning of the data is understood, and data is usable in the workflow of the receiver.¹

Beyond enabling the transmission of discrete data fields, the industry is struggling to implement “semantic” interoperability.

- Example: Read
- Requires context to know if the meaning is in present tense or past tense; electronic information needs sufficient context to be transferred with unambiguous meaning

¹ Source: InterSystems Corporation.
FHIR: Fast Healthcare Interoperability Resources

Next-generation standards framework created by HL7

Combines the best features of HL7’s v2, v3, and Clinical Document Architecture (CDA) product lines

Leverages the latest web standards and applies a tight focus on implementability

Built from a set of modular components called "Resources" which can be assembled into working systems that solve real-world clinical and administrative problems at a fraction of the price of existing alternatives

Can be used on mobile phone apps, cloud communications, EHR-based data sharing, server communication in large institutional healthcare providers, etc.

HL = Health Level 7
Why FHIR Is Better Than Other Standards

• Fast and easy implementation
• Multiple implementation libraries with examples to kick-start development
• Specification is free for use with no restrictions
• Interoperability out-of-the-box: base resources can be used as is OR adapted as needed—even for local requirements using profiles, extensions, terminologies, and more
• Evolutionary development path from HL7 v2 and CDA—standards can co-exist and leverage each other
• Strong foundation in web standards: XML, JSON, HTTP, OAuth, etc.
• Support for RESTful architectures, seamless exchange of information using messages or documents, and service-based architectures

XML = Extensible Markup Language
JSON = JavaScript Object Notation
HTTP = Hypertext Transfer Protocol
REST = Representational state transfer
APIs are used to pass data back and forth between software apps in a formalized way.\(^1\)

APIs help build and integrate application software, letting products or services communicate with other products or services without having to know they’re implemented.\(^2\)

Sources:
API, Pt. 2

• An interface that allows unrelated software programs to communicate, acting as a ‘bridge’ between the two applications
• Examples: third-party travel planning sites, like Expedia
  — The site does not generate its own data on the various airlines
  — It uses the API provided by each individual airline to plug into the flight scheduling software and assemble it into a single view.
API Examples

Download apps

Through settings, enter server information
Blockchain Technology
Defining Blockchain

“A blockchain is a decentralized, distributed, and public digital ledger that is used to record transactions across many computers so that any involved record cannot be altered retroactively, without the alteration of all subsequent blocks.”

Blockchain Parts

Blockchain is made up of four parts...

1. A distributed database
2. An append-only structure
3. Smart contracts
4. Incentives

that enable:

- Improved resiliency, security, and integrity
- A single source of truth with immutable records that eliminates variations and versions
- Reduced costs of reconciliation and manual processing steps
- Align incentives of participants, transfer value and bootstrap the funding of a network or development

The Chain

- Blocks are chained together through each block containing the hash digest of the previous block’s header, thus forming the *blockchain*.
  - If a previously published block were changed, it would have a different hash. This, in turn, would cause all subsequent blocks to also have different hashes since they include the hash of the previous block. This makes it possible to easily detect and reject altered blocks.

Healthcare Use Cases

**Patient financial transactions:**
- Bundled payments
- Transaction processing
  - Contracting data management
  - Price matching between hospital and distributor
  - Purchase order processing
  - Invoicing payment
- Track and trace pharmaceutical chain of custody
- Access personal health information

**AI = Artificial Intelligence**

**CDC = Centers for Disease Control and Prevention**

Sources:
3. Ibid. See #2 above.
Arizona’s Health Information Exchange
Member of: The Strategic Health Information Exchange Collaborative (SHIEC) is a national collaborative representing HIEs

The organization already represents 70+ HIEs, and these HIEs collectively cover more than 200 million people across the U.S.—well over half of the American population

There are more than 3,000 Arizona providers

National HIEs

“The Nationwide Health Information Network (NHIN) is a set of standards, services and policies that enable secure HIE over the Internet”

“The initiative is sponsored by the Office of the National Coordinator (ONC) for Health Information Technology (HIT), which began developing the NHIN in 2004”

Two HIE members to note are Carequality and Commonwell

- There are over 300 healthcare provider sites that share health data via the Carequality Interoperability Framework
- And there are over 100 Arizona ambulatory healthcare provider sites who are live with CommonWell Services

Artificial Intelligence
Artificial or Augmented Intelligence

Broadly refers to computing technologies that resemble processes associated with human intelligence, such as reasoning, learning and adaptation, sensory understanding, and interaction.

Machine learning is a method of data analysis that automates analytical model building.¹

Some are using machine-learning to make sense of varies and unstructured kinds of data, such as natural language text. Instead of pre-programmed instructions, machine learning allows the systems to discover patterns and derive its own rules.

Source:
Currently in Use

- Google (Assistant)
- Amazon (Alexa)
- Netflix
- Facebook
- Airlines (autopilots)
- Uber, Lyft
- Self-driving cars
- Turing and Enigma
Healthcare Use Cases (cont.)

Advanced analytics and research
- Ex: detect abnormalities in X-rays or diagnostic images (i.e., melanomas)
- Ex: precision medicine

Aid in the diagnosis of disease

Public health
- Early detection of infectious disease outbreaks and sources of epidemics

Health monitoring (FitBit, AppleWatch)
- Send alerts
- Share information with doctors
- Additional data points on the needs and habits of patients
APMs
Medicaid and Medicare
Arizona APMs

Accountable Health Communities Model is at Dignity Health (St. Joseph’s Hospital and Medical Center in Phoenix)

Bundled Payments for Care Improvement (BPCI) Advanced Model

- Cogent Healthcare of Arizona in Sierra Vista
- Tucson Orthopedic Institute
- Rodney D. Henderson, MD in Yuma
- Aia Hospitalists, LLC in Phoenix

Source:
Other Payer Advanced APMs are payment arrangements that fall into one of these categories and meet the Other-Payer Advanced APM criteria. These include:

- Medicaid
- Medicare health plans
  - Medicare Advantage, Medicare-Medicaid plans
  - Programs of All-Inclusive Care for the Elderly (PACE) plans
- CMS Multi-Payer Models
- Commercial and private payer arrangements
Conclusions

Transformation is happening in health care
• Technology is transforming healthcare
• Payment reform is transforming healthcare
• Legislation regularly transforms healthcare

You STILL have resources available to help
• HSAG can help:
  • with QPP
  • with the Opioid crisis
  • Advanced Analytics
  • Health Current partnership
Thank you!

Kim Salamone, Ph.D.
HSAG Vice President, Health Information Technology
602.801.6960 | ksalamone@hsag.com
Success in Alternative Payment Models

David Hanekom, MD
Tanya Wilkinson

Arizona Care Network
Levels of Practice Transformation Approaches

- Virtual Collaboration
- Monthly Touchpoints
- Onsite, Full Integration
• Executive Leadership team meets with PCP & team to review practice performance
• Goals of organization set & aligned with practice goals
• Agreed upon interventions & next steps discussed

• Integrated care team
  • RN Care Coordinator, Social Worker, Health Coach, Navigator, Pop Health MA
  • Serves the highly complex patient population

• RN Care Coordinator & Social Workers
• Referrals received directly from provider through Concierge
• Collaborative patient appointment for “warm handoff”
• Agreed upon care plan implemented

• Monthly visits with practices to discuss performance
• Discuss opportunities for improvement and develops tool kits for success
• Provides ACN network updates

PRIVILEGED AND CONFIDENTIAL
Virtual Collaboration

N Compass Care Coordination Care Hub
Matching Population Health Needs

Optimizing Resources to Maximize Impact

- **N Compass Programs**
  - Better at Home
  - Mercy Comprehensive Care Clinics

- **N Compass Care Services**
  - Central Referral
  - Transitions of Care
  - Complex Care Coordination

- **N Compass Services**
  - Concierge Services
Monthly Touchpoints

Clinical Performance Consultants
Practice Transformation

**Micro-Territories**

- The Provider Network and Clinical Performance roles merged to form the Clinical Performance Consultants (CPC)
- The CPC is a Provider support resource and the main point-of-contact for all ACN needs
- “Micro-Territories” provide the CPC team a better opportunity to work directly with practices to transform where needed and help fulfill the Quadruple Aim
Practice Transformation Program Outcomes

Program Expected Outcomes:

Practice-level outcomes
- Improvements in a practice's overall capacity to engage in transformation
- Improvements in administrative, quality improvement, IT, and community systems and clinical processes
- Changes in targeted care quality
- Changes in provider and staff knowledge, skills, behavior, satisfaction
- Improvement to practice’s network stewardship and utilization
- Increased utilization of ACN’s tools and resources, including N Compass Care Coordination, patient satisfaction training and Clinical Performance practice improvement toolkits

Patient-level outcomes
- Health status and outcomes for patients (Examples: A1c, blood pressure, depression level)
- Improvement for patient experiences with care
- Improved patient cost of care
- Awareness of the resources and tools available through ACN/ N Compass
### CPC & PCP Toolkits

**Primary Care Provider Pre-Visit Planning**

<table>
<thead>
<tr>
<th>Practice Name:</th>
<th>Date:</th>
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<table>
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<tr>
<th>Planning Check List</th>
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<tr>
<td>Athena</td>
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<tr>
<td>Parbo</td>
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<tr>
<td>Care Wallet</td>
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<tr>
<td>Secure Portal</td>
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<tr>
<td>Provider Roster</td>
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<tr>
<td>Care Coordination</td>
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**ACN Network Alignment**

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<tr>
<th>Quadruple Aim Meeting Goals</th>
<th>ACN Network Alignment</th>
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**Other Network Participation**

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<tr>
<td>Banner Health Network</td>
<td>Community Health</td>
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<td>Equity Health</td>
<td>Steward Health Care</td>
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<tr>
<td>Innovative Care Partners</td>
<td>Optum</td>
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<td>ASData</td>
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**Primary Care Provider Visit Agenda**

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<th>Practice Name:</th>
<th>Date:</th>
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<tr>
<th>Meeting Attendees:</th>
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**Meeting Topics**

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<tr>
<th>Athena</th>
<th>PRP</th>
<th>Other</th>
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<tbody>
<tr>
<td>Parbo</td>
<td>Quality</td>
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<td>Care Wallet</td>
<td>Cost/INK</td>
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<tr>
<td>Secure Portal</td>
<td>Provider Engagement</td>
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<td>Provider Roster</td>
<td>Patient Satisfaction</td>
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<td>Care Coordination</td>
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**Provider Roster**

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<th>Topic</th>
<th>Discussion</th>
<th>Follow-Up/Resolution</th>
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**Meeting Notes**

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**Arizona Care Network**

**ANNUAL SCREENING QUESTIONNAIRE**

**Preventative Care**

- Last Pneumonia Date
- Administered: Yes/No
- Declined: Yes/No
- Pneumonia Vaccine (1+yr. IDD)
- Yes/No
- Annual/Previously received: Yes/No

**Disease Management/Monitoring**

- BMI (Normal 18-25) Last BMI (Date)
- BM (BMI) < 18.5 (Matched at least 2 times last year) (Date)
- BM (BMI) 18.5-24.9 (Matched at least 2 times last year) (Date)
- BM (BMI) 25-29.9 (Matched at least 2 times last year) (Date)
- BM (BMI) 30-34.9 (Matched at least 2 times last year) (Date)
- BM (BMI) 35+ (Matched at least 2 times last year) (Date)

**Depression Screening Module**

- Have you been feeling sad, blue, or worthless a lot of the time or most of the time, for at least 2 weeks in a row? (Date)
- Have you been feeling this way all the time or nearly all the time? (Date)
- Have you been feeling like you have been bothered by any of the following things? (Date)
- Feelings of worthlessness or hopelessness (Date)
- Feelings of guilt (Date)
- Feelings of anxiety (Date)
- Feelings of helplessness (Date)
- Feelings of hopelessness (Date)
- Feelings of depression (Date)
- Feelings of suicide (Date)
- Feelings of death (Date)

**Social History**

- **Medical History**
- **Family History**
- **Psychosocial History**
- **Behavioral Health History**
- **Current Medications**
- **Previous Medications**
- **Allergies**

**Diagnosis**

- **Diagnosis**
- **Treatment**
- **Follow-Up**

**Follow-Up**

- **Follow-Up**
- **Next Visit**

**Final Visit**

- **Final Visit**
- **Next Visit**

**Arizona Care Network**

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- **Follow-Up**

**Follow-Up**

- **Follow-Up**
- **Next Visit**

**Final Visit**

- **Final Visit**
- **Next Visit**
Joint Leadership Committee Meetings

- Large Practices Meet Quarterly
- Smaller Practices Meet Annually to Biannually
- Leadership Presence
- JLC Deck with Quarterly Performance Data
  - Quality and preventative care measurement
  - In network referral measurement
  - Cost and utilization rates
Onsite, Full Integration

Comprehensive Care Clinics
N Compass Comprehensive Care Clinics

Supporting Vulnerable Mercy Care Patient Population

- Integrated primary care and behavioral health services
- Three clinic locations valley-wide
- Embedded team:
  - RN Care Coordinator
  - Social worker
  - Healthcare Navigator
  - Population Health MA
  - Behavioral Health Coach
- Serving the complex/high need/high risk MCP members
  - 9,000 current ACN members are considered SMI (Seriously Mentally Ill)
Integration + Transformation = Collaboration

Shelli Ross
Lindsay Dietz

Arizona Alliance of Community Health Centers (AACHC)
Integration + Transformation = Collaboration

September 16, 2019
AACHC

- Founded in 1985
- Primary Care Association (PCA) in Arizona
- **23 Members**, 20 of which are Health Center Program Grantees or Federally Qualified Health Centers
- **175 sites** in rural and urban communities across Arizona
- Member of the National Association for Community Health Centers (NACHC)
Collaborative Ventures Network (CVN)

Business Objectives

• Collaboration across communities for affordable quality health care
• Statewide community-based patient-centered primary care network
• Data-based benchmarking and decision making
• Demonstrable value-based care through QI, health outcomes, and lower costs
• Fiscally sustainable operations to meet continued growth in populations served

Business Model

• 18 CVN Corporate Members
• 26 HCCN Participating Health Centers
• 17 HAN Participating Provider Entities

HealthyArizona.org
AACHC – CVN Roles

Primary Care Association

- Advocacy for BPHC Grantees
- Support CHC Services throughout AZ
- Technical Assistance, Education & Training
- 11 Peer Networking (QI, CFO, etc.)

Integrated Services Network

- Clinical Integration (IPA)
- Implementation of “Best Practices”
- Integrated Data Management
- Other Collaborative Business Services
AACHC and CVN Roles
Services provided by CHCs
Population Served in 2018

704,000 Patients served

- 50% Identify as Hispanic
- 49.8% Under 200% FPL (federal poverty limit)
- 17% No Insurance
- 47% AHCCCS
- 22% English as a Second Language
- 16% Live in Public Housing
Primary Care Association (PCA)
Bureau of Primary Health Care (BPHC)
CEO: John McDonald

1. Meaningful Use of ONC-certified EHRs
2. Adoption of Technology Enabled QI Strategies
3. Engagement in HIE (Health Current)
4. Improvement of Healthy People 2020 Measures

Purpose:
To strengthen the quality of care & improve patient health outcomes achieved by FQHCs & Look-Alikes through:
1. Meaningful Use of ONC-certified EHRs
2. Adoption of Technology Enabled QI Strategies
3. Engagement in HIE (Health Current)
4. Improvement of Healthy People 2020 Measures

Mission is to foster collaborative business activities which enhance Community Health Centers’ individual abilities to meet the needs of Arizona’s uninsured, underinsured, & underserved.

Statewide Health Information Exchange (HIE):
Electronically links health care organizations through a single network for secure & private sharing of electronic health information. Provides assistance to practices through Pi Institute.

Public & Private Partnership
Non-Profit

Health Center Controlled Network
Purpose:
To strengthen the quality of care & improve patient health outcomes achieved by FQHCs & Look-Alikes through:
1. Meaningful Use of ONC-certified EHRs
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3. Engagement in HIE (Health Current)
4. Improvement of Healthy People 2020 Measures

Clinically Integrated Provider Network (CIPN)
Enables FQHCs & Look-Alikes to form a statewide provider network for developing clinical pathways, advancing value-based care, & stronger negotiating/contracting power with health plans.

Practice Innovation Institute

Transforming Clinical Practice Initiative (TCPi)

1. Transform Practice
2. High Performance
3. Reduce Utilization
4. Scale evidence based practices
5. Increase savings
6. Promote value-based payment systems

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This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under Grant No. H23Q000241.
AACHC+CVN+Pii = Collaboration

Overlapping Goals

- Ongoing Data Driven Quality Improvement
- Person and Family-Centered Care design
- Development/Transformation toward sustainable Business Operations
- Population Health Management
<table>
<thead>
<tr>
<th>UDS Clinical Measure</th>
<th>% Goal</th>
<th>Code</th>
<th>CMS Measure ID</th>
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<tbody>
<tr>
<td>Prenatal Entry 1st Trimester</td>
<td>77.50%</td>
<td>MICH-10.1</td>
<td>N/A</td>
</tr>
<tr>
<td>Low Birth Weight Babies (&lt; 2500)</td>
<td>&lt; 7.5%</td>
<td>MICH-8.1</td>
<td>N/A</td>
</tr>
<tr>
<td>2 year old Up to Date Immunizations</td>
<td>80%</td>
<td>IID-8</td>
<td>CMS117v5.</td>
</tr>
<tr>
<td>Cervical cancer Screening</td>
<td>93.00%</td>
<td>C-15</td>
<td>CMS124v5.</td>
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<td>Diabetes A1c &lt;8</td>
<td>–</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Diabetes A1c 8.0 – 9.0</td>
<td>–</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Diabetes A1c &gt;9.0</td>
<td>&lt; 16.1%</td>
<td>D-5.1</td>
<td>CMS122v5.</td>
</tr>
<tr>
<td>Diabetes A1c ≤9.0</td>
<td>–</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Controlled Hypertension</td>
<td>61.20%</td>
<td>HDS-12</td>
<td>CMS165v6.</td>
</tr>
<tr>
<td>Child Weight Assessment/Counseling</td>
<td>55%</td>
<td>N/A</td>
<td>CMS156v6.</td>
</tr>
<tr>
<td>Adult Weight Screening &amp; Follow Up</td>
<td>31.00%</td>
<td>N/A</td>
<td>CMS99v6.</td>
</tr>
<tr>
<td>Tobacco Assessment &amp; Intervention</td>
<td>None</td>
<td>N/A</td>
<td>CMS138v5.</td>
</tr>
<tr>
<td>Asthma Treatment</td>
<td>None</td>
<td>N/A</td>
<td>CMS126v5.</td>
</tr>
<tr>
<td>Coronary Artery Disease &amp; Lipid Rx</td>
<td>None</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Ischemic Vascular Disease &amp; Aspirin</td>
<td>None</td>
<td>N/A</td>
<td>CMS164v6.</td>
</tr>
<tr>
<td>Colon Cancer Screening</td>
<td>70.50%</td>
<td>C-16</td>
<td>CMS130v5.</td>
</tr>
<tr>
<td>Depression Screening &amp; Follow Up</td>
<td>None</td>
<td>N/A</td>
<td>CMS2v5.</td>
</tr>
<tr>
<td>New HIV Cases Seen Within 90 days</td>
<td>None</td>
<td>N/A</td>
<td>CMS2v5.</td>
</tr>
<tr>
<td>Dental Sealants in Children</td>
<td>28.10%</td>
<td>OH-12.2</td>
<td>CMS27v5.</td>
</tr>
</tbody>
</table>
AACHC had identified the need for health centers to maximize the use of HIT

Identified that TCPI and HCCN funding had some alignment
  - PII overlapped with HCCN and other EHR and QI projects

Could FQHCs take on 2 projects while understaffed?
  - Meetings held together to minimize health center burden

CMS (PII) and HCCN (HRSA) measures aligned.
  - HP2020 measures: Diabetes, Colorectal Cancer, Immunizations, Cervical Cancer and Hypertension
Success Stories

• Sun Life Family Health Center
  • Used HIT to improve efficiencies and outcomes

• Patient empanelment
  • High risk patient coordination
  • HIE alerts
  • Modified workflows around the HIE alerts
Thank You

Shelli Ross - AACHC
Senior Director, Quality and Data Management

Lindsay Dietz – CVN/HCCN
CVN Administrator for Program Services - HCCN
Project Manager
The Importance of Patient & Family Engagement

Priya Radhakrishnan, MD
Pii Medical Advisor
PATIENT & FAMILY ENGAGEMENT:
THE TCPI- PII EXPERIENCE

Priya Radhakrishnan, MD, FACP
Physician Advisor Pii
Patient & Family Engagement Co-Champion, TCPI PFE Workgroup
Chief Academic Officer, HonorHealth
TCPI PFE Program Components

- Inclusion of the patient voice in practice operations
- Use of e-technology to engage patients & family
- Measurement of patient health literacy
- Shared decision-making among clinicians & patients
- Assessment to gauge patient readiness to be “activated” as a partner in their care
- Support for patient medication use
Integrating PFE into Quality Improvement

- SoDH
- Patient Activation
- Joy in Practice
- Shared Vision

Photocredit: meyerfoundaiton.org
Forging Ahead

- Policy
- Practice
- Platforms

Patients Voices need to be heard

Photocredit: Istockphot.com
Review of Pii Accomplishments & Recognitions

Stacey Rochman
Jenn Barrett

Practice Innovation Institute
History of Pii

- The Centers for Medicare & Medicaid Services (CMS) launched the *Transforming Clinical Practice Initiative* (TCPI) in 2015

- TCPI
  - was designed to support more than 140,000 clinician practices in sharing, adapting and further developing their comprehensive quality improvement strategies
  - is one part of a strategy advanced by the Affordable Care Act to strengthen the quality of patient care and spend health care dollars more wisely
History of Pii

• After being awarded a 4-year / $14.6M grant, the **Practice Innovation Institute** (Pii) was created to serve as Arizona’s Practice Transformation Network (PTN)

• Pii is a collaboration between Health Current and Mercy Care
History of Pii

- Commitments made ✓
- Recruitment occurred ✓
- Team was assembled ✓
- And we hit the ground running!
The vision of the Practice Innovation Institute is to help clinicians transform their practices into entities that make meaningful improvements in patients’ health and wellbeing.

We do this by driving continuous improvement within the clinical, operational and financial areas needed to thrive in the new world of healthcare.
Our mission is to support clinician efforts to transform their practices bringing meaningful improvement in their patients’ health and wellbeing. We do this through engagement and collaboration, by providing them with:

– Coaching
– Education
– Training
– Data and data analytics

We believe that high functioning and innovative ideas bring joy in practice, improved patient care, and a better patient experience.

ENGAGE
Prepare 2,500 Arizona clinicians for participation in value-based, alternative payment models

Pii Focus:
• Physical & behavioral health integration
• Population health
• Patient & family engagement
• Practice innovation & joy

TRANSFORM
• Outreach
• Education
• Coaching
• Direct Assistance

REWARD
• Improved Care Coordination
• Efficient Workflows
• Financial Success
Pii Commitments

Based on TCPI commitments

1. Support more than 140,000 clinicians in their practice transformation work
2. Improve health outcomes for millions of Medicare, Medicaid and CHIP beneficiaries and other patients
3. Reduce unnecessary hospitalizations for 5 million patients
4. Generate $1 to $4 billion in savings to the federal government and commercial payers
5. Sustain efficient care delivery by reducing unnecessary testing and procedures
6. Transition 75% of practices completing the program to participate in Alternative Payment Models
7. Build the evidence base on practice transformation so that effective solutions can be scaled
Pii Commitments

1. Support more than 2,500 clinicians in their practice transformation work

2. Improve the health outcomes for 19,032 individuals

3. Avoid 65,881 unnecessary hospitalizations

4. Generate $81,549,90 in savings

5. Avoid 2,737 unnecessary tests & procedures

6. Prepare 75% of enrolled clinicians for value-based payment models

Aim 7 – build the evidence base on practice transformation so that effective solutions can be scaled
Pii Participants

- Pediatric Clinically Integrated Network
- Outpatient Behavioral Health
- Specialty Practices
- Crisis services, Corrections
- Integrated Health Homes
- Statewide Health Information Exchange
- Mercy Care
- Equality Health Network

FQHC’s
Pii Team

• Steering Committee
• Management Team
• Practice Transformation Consultants
• HIE Account Managers
• Data Team
• Project Managers
• Medical Advisors
• and lots of other staff from Health Current and Mercy Care!
Pii Collaboration

- Health Services Advisory Group (HSAG)
- Arizona Alliance for Community Health Centers (AACHC)
- Phoenix Children’s Care Network
- Equality Health
Pii Clinical Advisory Council

Pii Physician Advisors:
Dr. Don Fowls & Dr. Priya Radhakrishnan

Council Members:

– Dr. Bryan Davey
– Dr. Mark Callesen
– Dr. Michael Franczak
– Paul Galdys
– Valerie O’Connell
– Dr. Mandeep Sahani
– Ron Smith

– Nick Stavros
– Dr. Mark Stephan
– Troy Stone
– Dr. Michael Sucher
– Dr. Ching Wang
– Stephen Weiss
– Dr. Robert Williamson
Pii Approach

• Pii is a peer-based learning network designed to coach, mentor, and assist clinicians and their practice staff in developing core competencies specific to practice transformation.

• This approach allowed practices to become actively engaged in their transformation and ensured collaboration across a broad community of practices, thereby creating, promoting, and sustaining learning and improvement across the health care system.
Pii Services Provided

• Team of Practice Transformation Consultants (PTCs)
• Utilized the TCPI Change Package as a roadmap for driving practice transformation
• Countless hours of consulting provided to Pii practices at no cost
Use of Health Information Technology

• Health Information Exchange (HIE)
  – Access to real time information is critical in facilitating care and care coordination
  – Has led to reduction in unnecessary services

• CareQuotient
  – Population health & analytics tool provided to Pii participants at no cost to them
  – Allowed users to have exposure to a pop health tool and to identify how can be utilized in their processes

• CareUnify
  – Care Management Tool
  – Care Pathways
  – Risk Stratification
Pii Conferences & Trainings

Pii offered many opportunities for learning & collaboration

• Excel & Change Management Training
• Pii Educational Series Workshops
• Prescription for Change Opioid Conference
• Collaboration with Support & Alignment Networks (SANS)
  – APA Collaborative – The Quality-Cost Question – A Listening and Learning Symposium
  – PCPCC/NNCC - Addressing Preventative Visits (Collaborative with ASU)
  – ACP Tackling The Opioid Crisis: A Practical Approach to Understanding & Addressing the Problem
  – PCPCC – Parent to Parent – Strengthening PFE
• AACHC – HIT Symposium – Learning Collaborative
Mini “Pii” Sessions

Designed for Pii participants to share information/experiences.

Thank you to the following organizations for presenting slices of Pii:

- Community Medical Services
- GB Family Care
- Horizon Health & Wellness
- Jewish Family & Children’s Services
- La Frontera EMPACT SPC
- Maricopa Integrated Health System
- MVP Kids Care
- North Country HealthCare
- RI International
- Partners in Recovery
- Phoenix Medical Group
- Piller Child Development
- Sun Life Family Medical Center
Pii Emails & Newsletters

Tools used to share information with Pii participants including:

- Success stories
- Upcoming conferences, webinars, and other education opportunities
- PTN progress against commitments
- Updates from CMS
- “News you need to know”

Available on Pii website
TCPI Medication Management and Opioid (MMO) Initiative

• Dedicated focus to assist in battling the opioid crisis
• Provided education on initiatives, strategies, and treatment modalities
• Shared access to resources to assist prescribers
Our PTN was well represented at annual conferences throughout the program and was often recognized for successful efforts!

Joining us was:

- Dr. Jodi Carter (PCCN) – 2016 CMS Quality Conference
- Dr. Guatam Aggarwal (Native Health) – 2018 National Expert Panel
- Amy Pugsley (RI International) – 2019 CMS Quality Conference
- Megan Lipman (JFCS) - 2019 CMS Quality Conference
- Dominic Miller (SB&H) – 2019 TCPI Exposition

Thank you
In addition to hosting events, Pii has presented at many conferences including:

- Southwestern School for Behavioral Health Studies (SWS)
- ASU Center for Applied Behavioral Health Policy Annual Summer Institute
- Health Current Annual Summit & Trade Show
- American College of Physicians (ACP) National meeting
- Healthcare Financial Management Association (HFMA)
- State of the State (Hertel Report)
- AHCCCS MCO Meetings
## Pii Commitments Met (EXCEEDED)!

<table>
<thead>
<tr>
<th>AIMS</th>
<th>Commitment / Target</th>
<th>Status</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIM 1 – Enrollment</td>
<td>2,500 Clinicians</td>
<td>2,635*</td>
<td>105%</td>
</tr>
<tr>
<td>AIM 2 – Improve Health Outcomes</td>
<td>19,032 improved</td>
<td>19,019*</td>
<td>100%</td>
</tr>
<tr>
<td>AIM 3 – Reduce Unnecessary Hospital Use</td>
<td>65,881 avoided hospitalizations</td>
<td>68,143*</td>
<td>103%</td>
</tr>
<tr>
<td>AIM 4 – Reduce Costs</td>
<td>$81,549,090</td>
<td>$155,632,824*</td>
<td>191%</td>
</tr>
<tr>
<td>AIM 5 – Reduce Unnecessary Tests &amp; Procedures</td>
<td>2,737 reduction</td>
<td>7,897*</td>
<td>289%</td>
</tr>
<tr>
<td>AIM 6 – Transformation</td>
<td>75% of enrolled clinicians in an APM (1,875 clinicians)</td>
<td>1,921</td>
<td>102%</td>
</tr>
<tr>
<td>AIM 7 – Create evidence base</td>
<td>263 Exemplary Practices</td>
<td>276 (105%)</td>
<td>101%</td>
</tr>
<tr>
<td></td>
<td>34 Early Exemplary Practices</td>
<td>25 (74%)</td>
<td></td>
</tr>
</tbody>
</table>

*as of end of Q15
A Pii Exemplar Practice is one that meets the following criteria:

- Practice has met phase 3 and/or above
- Practice has implemented one of the six PFE metrics
- Practices are performing on one or more of the following TCPI service delivery aims:
  - Health outcomes at benchmark standards
  - Reduction in unnecessary hospitalizations
  - Cost savings to payers
  - Reduction in unnecessary tests and procedures
Pii Exemplary Organizations

- A New Leaf
- Agave Pediatrics
- Arizona’s Children Association
- Bayless Healthcare Group
- Bethesda Pediatrics of Queen Creek
- Chandler Pediatrics
- Chicanos Por La Causa
- Children’s Clinics for Rehabilitative Services
- Community Bridges, Inc.
- Community Medical Services
- Community Partners Inc
- ConnectionsAZ
- Crisis Preparation and Recovery, Inc.
- Desert Senita Community Health Center
- Desert Shores Pediatrics
- Desert Sun Pediatrics
- Desert Valley Pediatrics
- DMG – Comprehensive Health Center
- GB Family Care
- Gilbert Pediatrics
- Healing Hearts Pediatrics
- Horizon Health and Wellness
- Jewish Family and Children’s Services
- La Frontera Arizona / EMPACT SPC
- Lifewell Behavioral Wellness
- Marc Community Resources, Inc.
- Maricopa County CHS
- Mesa Pediatrics Professional Association

53 Organizations!!
# Pii Exemplary Organizations

- MomDoc
- Moon Valley Pediatrics
- Mountain Park Health Center
- MVP Kids Care
- Native Health
- North Country HealthCare
- North Valley Pediatrics
- OrthoArizona
- Paradise Pediatrics
- Partners in Recovery
- Pendleton Pediatrics
- Phoenix Children’s Medical Group
- Phoenix Medical Group
- Piller Child Development
- Pulmonary Consultants
- Resilient Health
- RI International
- Southwest Behavioral & Health Services
- Southwest Network
- St Elizabeth’s Health Center
- Sun Life Family Health Center
- Sunset Community Health Center
- Terros Health
- Valle del Sol
- Wesley Community and Health Centers
Pii Early Exemplary Organizations

- Arizona Otolaryngology
- Biltmore Ear Nose & Throat, PC
- Catalina Pointe Arthritis & Rheumatology Specialists
- Circle the City
- Crazy About Kids Pulmonary
- Native American Connections
- Neuromuscular Research Center
- Relieve Allergy, Asthma & Hives
- San Tan Allergy & Asthma
- Touchstone Behavioral Health
- True Care MD
- Valley Anesthesiology

Early Exemplary organizations are those that came **THIS CLOSE** to meeting all the requirements.
TCPI 5 Phases of Transformation

Pii Practice Transformation Consultants worked with our organizations to help them move through the *5 Phases of Transformation*

58 Pii organizations successfully completed!
The Value of Pii Practices

- Pii practices demonstrate **quality improvement processes** that far exceed typical practice environments and have implemented **evidence-based sustainable solutions** that benefit the patient and payer.
- Pii Practices have received **education on management protocols** and have **integrated targeted approaches** for outreach to address high risk patients, outstanding screenings, and other care needs.
- Pii Practices have implemented **Patient and Family Engagement** metrics.
- Pii Practices have integrated **Health Information Technology** into their workflow including connectivity to Health Current, Arizona’s statewide HIE.
Special Recognitions
Recognized at 2016 CMS Quality Conference for **Top Practice Story**

- Identified higher than average inpatient admission rate for functional constipation
- Identified more cost effective and safer solution
- Reduced inpatient admissions & saved $1.9 million over 2 years
Partners in Recovery

Recognized at 2017 National Expert Panel for Patient and Family Engagement

- Support of Patient Voices in Governance and Operational Decision-Making
- Shared Decision-Making
- E-Tools
- Health Literacy
- Patient Activation
Recognized at 2018 CMS Quality Conference for **Patient and Family Engagement**

- As a Patient Centered Medical Home (PCMH), DSCHC is committed to providing services that meet the pressing healthcare needs of its community
- Created two community programs to address obesity
FQHC Cluster

- 4 FQHC’s were recognized for focused efforts improving **Diabetes Control**:
  - *Native Health*
  - *Horizon Health & Wellness*
  - *St. Elizabeth's Health Center*
  - *Mountain Park Health Center*

- Focused area for these FQHCs has been **diabetes control**

- Management of these diabetic members showed an **improvement rate** in A1c values

- An improvement in this complex population demonstrates the effectiveness of focused management of chronic disease members with abnormal lab values
Recognized for focused efforts regarding **Opioid Management**

- Medical Director took on role of champion to address the opioid epidemic within the organization
- Revised /added policy & procedure to implement the required AZ prescribing guidelines
- Identified patients relying on long-term use of prescription opioid for chronic management
- Developed relationships with these patients and developed treatment plans to mitigate their risks (including tapering plans, alternative treatments, and proper referral to behavioral health and/or MAT provider)
- Process included regular checks of PMP for any opioid prescription outside of their service
- Evaluation of 2 HEDIS opioid measures indicates consistent decrease of dosage and length of use since inception of above actions
Recognized for benchmark performance in Care Transitions

- Development and implementation of Hospital Navigator Team
- Efforts have led to:
  - Decreases in admissions
  - Increased follow-up appointment adherence
  - Increased healthcare cost savings
  - Increased integration of patient care
- Dominic Miller, SB&H Vice President of Outpatient Services, presented at 2019 TCPI Exposition
Special recognition by CMS for **Excellence in Person and Family Engagement**
Identified as a **Shining Star Practice** based on their exemplary performance

- Joined Pii in May 2016
- Completed the *5 Phases of Transformation* in September 2018
- Met the TCPI definition of “Graduated” by joining a Medicaid APM
- Achieved success in
  - Reducing unnecessary hospital and ED use (Aim 3)
  - Reduction of unnecessary healthcare costs (Aim 4)
Resources

• [www.piiaz.org](http://www.piiaz.org)
  – Newsletters
  – Exemplary Stories
  – Conference and Mini Pii Session Materials
  – Helpful Links
• [www.healthcarecommunities.org](http://www.healthcarecommunities.org)
• [www.healthcurrent.org](http://www.healthcurrent.org)
• [www.mercycareaz.org](http://www.mercycareaz.org)
THANK YOU!!!!!