

Highlight and Share, Don't Rank & Spank! Motivating Clinicians for QI

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NAACOS- September 8, 2022

BY THE NUMBERS



27 HOSPITALS

500+ SITES OF CARE



Top 12

NOT-FOR-PROFIT HEALTH SYSTEM



Top 10

IN QUALITY AMONG NATIONAL HEALTH SYSTEMS



75K

TEAM MEMBERS

22K

NURSES

10K

PHYSICIANS



3M UNIQUE PATIENTS

1.3M VALUE-BASED LIVES



53

INTEGRATED HEALTH & SAFETY MEASURES TRACKED



\$2.5B+

COMMUNITY BENEFITS IN 2020



10K

VOLUNTEERS

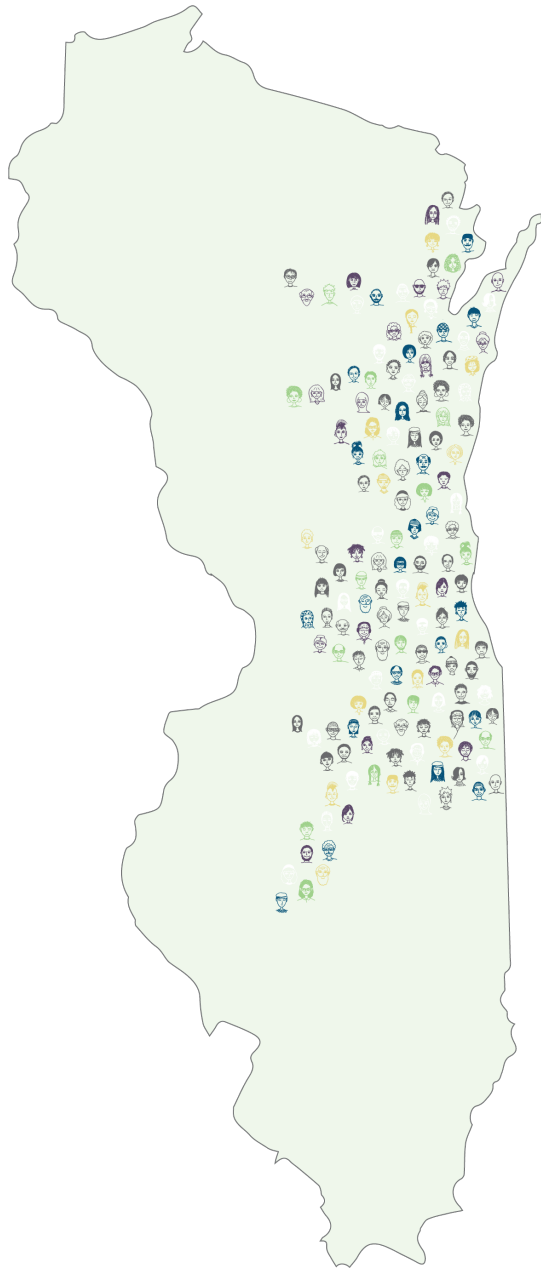


1.2M+

LIVWELL APP DOWNLOADS

Advocate Aurora Health

MSSP Participation for 2022



Wisconsin:

❖ Enhanced

- 67,956 Beneficiaries¹
- 11 TINs
- 5,000+ clinicians
- Downside risk
- Advanced Alternative Payment Model (AAPM)
- Start date: 2017

Illinois:

❖ Basic Level E

- 103,370 Beneficiaries¹
- 401 TINs
- 6,000+ clinicians
- Downside risk
- Advanced Alternative Payment Model (AAPM)
- Start date: 2012

**\$414 million in generated savings
since joining program in 2012**

Vision

Transformation 2025 at a glance

Top decile quality outcomes by 2025



Safety • Quality • Health Equity • Financial Strength

Team Member Powered. Community Inspired.

 AdvocateAuroraHealth®

 AdvocateAuroraHealth®

2021 MSSP Results

Priority Quality Measures	2020 Performance Year AURORA ACCOUNTABLE CARE ORGANIZATION LLC (Enhanced)	2020 Performance Year ACCOUNTABLE CARE ORGANIZATION OF AURORA LLC (Track 1)
Medicare Wellness Visits*	71.0%	71.0%
Controlling High BP	83.4%	85.9%
Diabetes A1c poor control	11.1%	9.5%
Colorectal Cancer Screening	82.9%	81.9%
Breast Cancer Screening	82.6%	83.7%

*Internal measure all patients all payers

Internal Quality Priorities *internal data

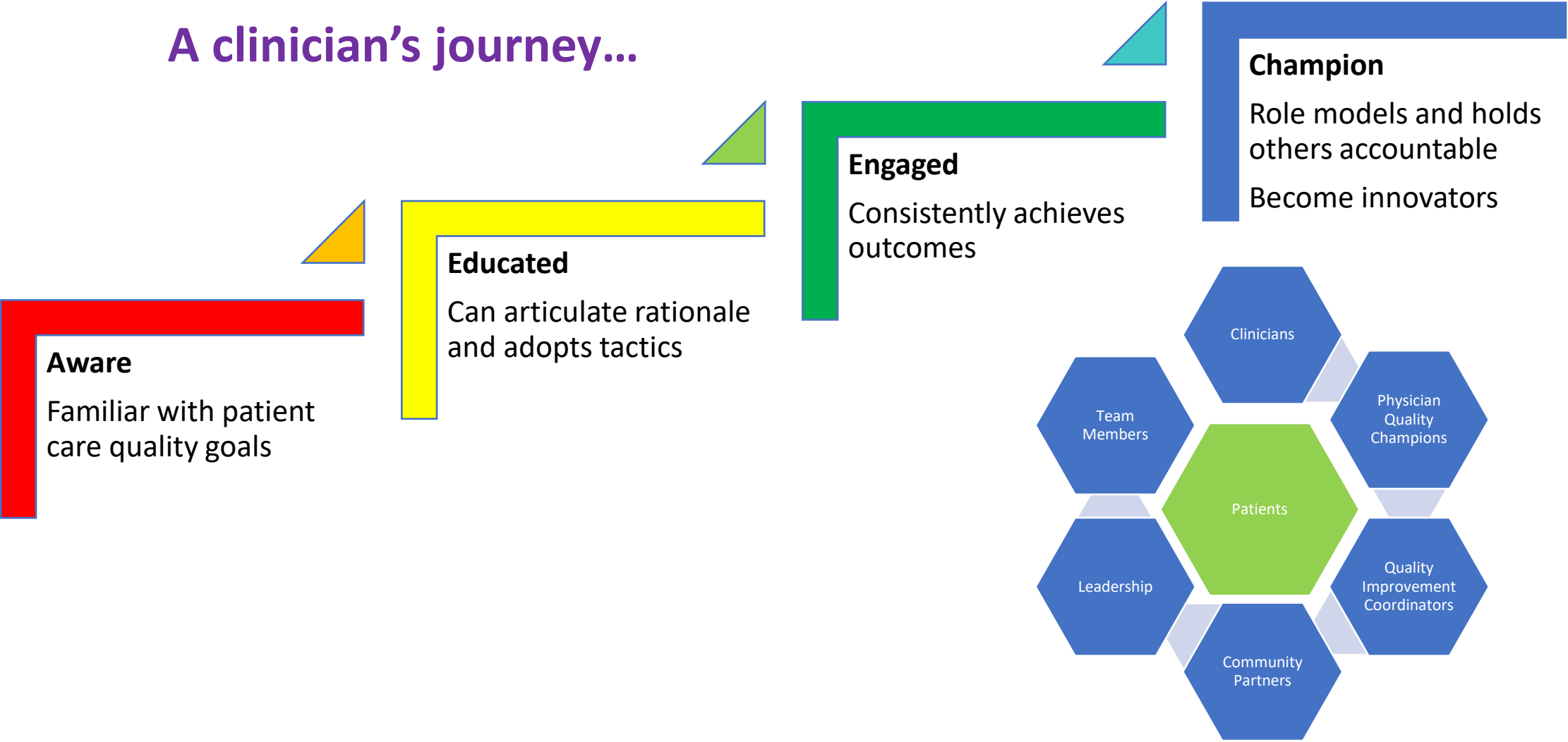
Priority Quality Measures	2020 YE (Previous internal scoring)	2021 YE (Previous internal scoring)	2022 6/1/22 Primary Care Population Health Index
Medicare Wellness Visits	71%	78%	78%
Controlling High BP	82%	85%	83.5%
Diabetes A1c control**	71%	74%	76.8%
Colorectal Cancer Screening	81%	81%	
Breast Cancer Screening			78.9%

***All patients all payers**

****Patients in control**

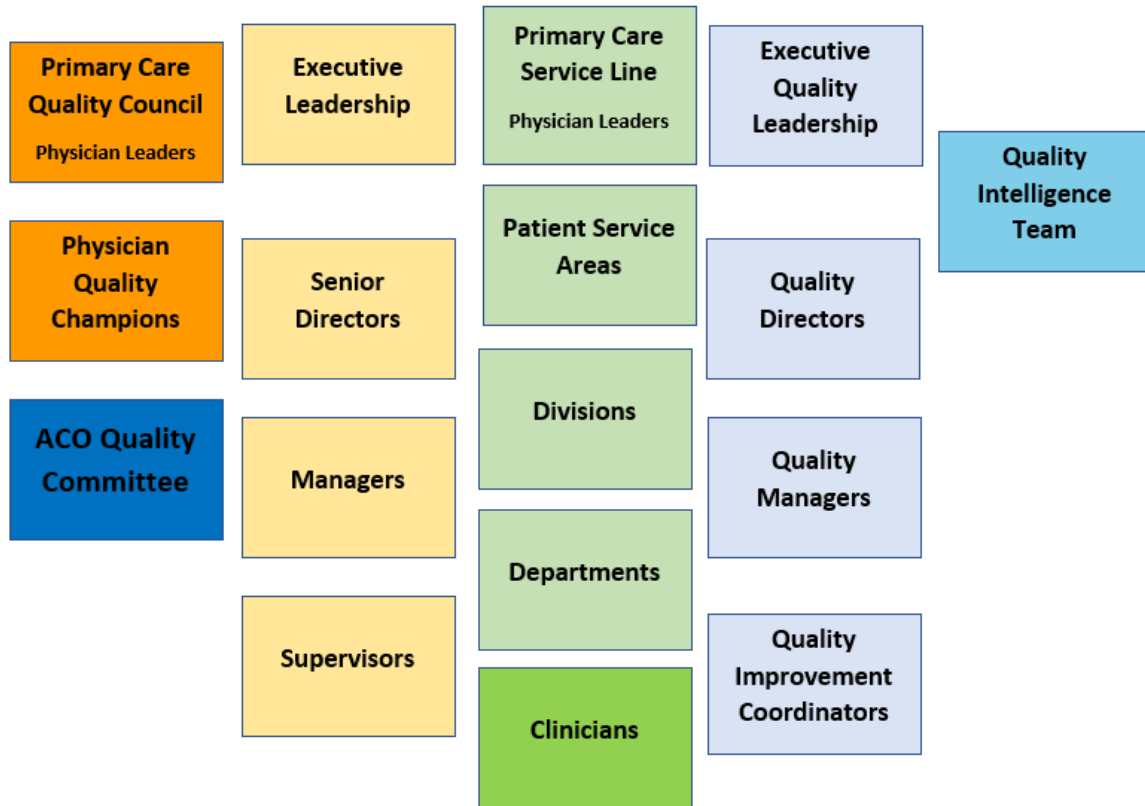
Cultivating Champions

A clinician's journey...



We help people live well...

Structure



Quality Dashboard

- Realtime
- Interactive
- Workable reports

Tools

Best Practice Toolkit

- Evidence based practices
- EPIC Workflows

Quality Processes

- Collaboration with clinicians and team
- Audits

ACO Quality Committee Purpose

To improve the quality of care and experience of the beneficiaries through the development and monitoring of an actionable improvement plan.


ACO Quality Committee member roles and responsibilities

- Be knowledgeable about the program quality measures
- Actively participate in committee meetings
- Review quality reports to identify opportunities
- Provide leadership and guidance on quality performance
- Be a role model; implement improvement ideas in your practice
- Act as a liaison to your respective area (clinic, dept, etc.) to communicate updates, educate on improvement strategies

2022 Quality Plan

Measure	Action Plan	Performance as of June 1, 2022 IMGQRD
<p>At-Risk Population- Hypertension ACO-28 (HTN-2) Hypertension (HTN-2): Controlling High Blood Pressure Quality ID # 236 (Note: Similar measure IMGQ Dashboard)</p> <p>Percentage of patients 18 - 85 years of age who had a diagnosis of hypertension overlapping the measurement period and whose most recent blood pressure was adequately controlled (< 140/90 mmHg) during the measurement period.</p>	<p>Utilizing dashboard to outreach to patients with elevated BPs to schedule BP recheck visits</p> <p>Capturing patient reported BP from home monitoring</p> <p>Repeat BP when initial BP is elevated during visit</p> <p>Medication adherence – remove barriers encourage 90-day refill</p>	<p>83.5% (Target 82%/Stretch 84%)</p>
<p>At-Risk Population- Diabetes ACO-27 (DM-2) Diabetes Hemoglobin A1c (HbA1c) Poor Control (>9%) Quality ID # 001 (Note: Similar measure is also CMS Part C Star measures and is included in the IMGQ Dashboard)</p> <p>Assesses adults 18–75 years of age with diabetes (type 1 and type 2) who had the following:</p> <ul style="list-style-type: none"> • Hemoglobin A1c (HbA1c) testing • HbA1c poor control (>9.0%) 	<p>Scheduling follow-up Diabetes appointments prior to the patient leaving</p> <p>Utilizing Point of Care Testing to capture A1c at the time of the office visit</p> <p>Obtaining labs prior to office visit to allow for adjustments of treatment plan to occur during visit</p> <p>Leverage the diabetic educators</p> <p>Provide 90-day refill to encourage 3-month A1c recheck</p>	<p>Hgb A1C Testing</p> <p>76.8% (Target 74%/Stretch 77%)</p> <p>Hgb A1C < 8.0%</p> <p>73.7% (Target 70%/Stretch 72%)</p>

2022 Quality Plan continued...

Measure	Action Plan	Performance as of June 1, 2022 IMGQRD
<p>Breast Cancer Screening ACO-20 (PREV-5) Quality ID # 112 (Note: Similar measure is also CMS Part C Star measures and is included in the IMGQ Dashboard)</p> <p>Percentage of women 50 - 74 years of age who had a mammogram to screen for breast cancer in the 27 months prior to the end of the measurement period.</p>	<p>Scheduling Mammograms same day</p> <p>Leveraging Radiology Techs for outreach</p> <p>Verifying mastectomies and ensuring laterality is documented accurately</p>	 <p>78.9% (Target 79%/Stretch 81%)</p>
<p>Medicare Wellness Visits Internal Measure (IMGQ Dashboard) Percent of Medicare patients ages 21 and older who have had a Medicare Wellness visit that is billed or pending in the past 12 months.</p>	<p>Scheduling MWV for following year at checkout</p> <p>Leveraging RNs to help complete MWV</p> <p>Utilizing MWV outreach process</p>	<p>78% (Target 75%/Stretch 80%)</p>

Population Health Index Dashboard: Executive

WI Quality Measures

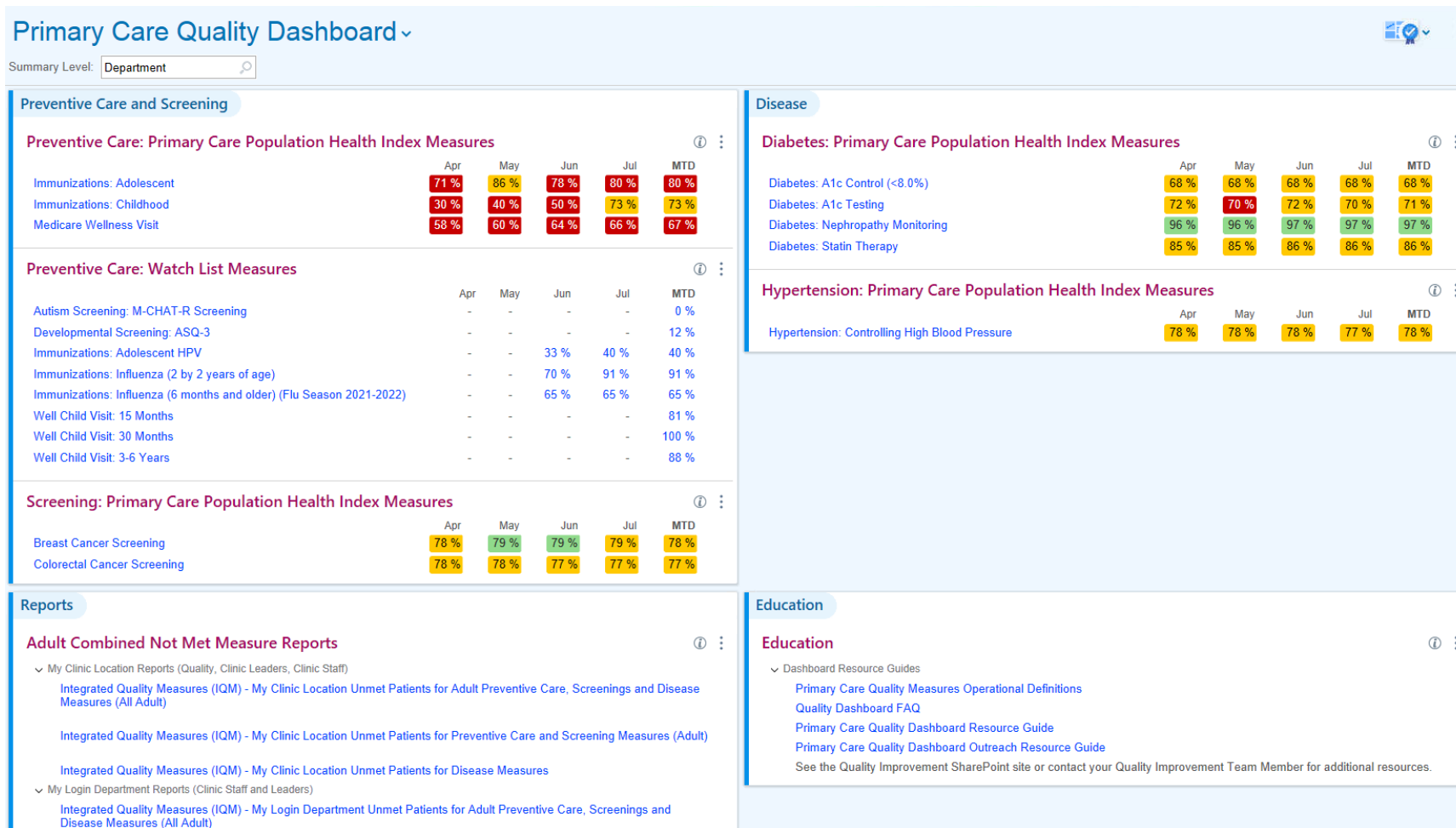
Aurora Service Area ⓘ

	Apr	May	Jun	Jul	MTD
Breast Cancer Screening	78 %	79 %	79 %	79 %	80 %
Colorectal Cancer Screening	79 %	79 %	79 %	79 %	79 %
Diabetes: A1c Control (<8.0%)	73 %	74 %	74 %	75 %	75 %
Diabetes: A1c Testing	77 %	77 %	77 %	77 %	77 %
Diabetes: Nephropathy Monitoring	95 %	95 %	95 %	95 %	95 %
Diabetes: Statin Therapy	84 %	84 %	85 %	85 %	85 %
Hypertension: Controlling High Blood Pressure	83 %	84 %	84 %	84 %	84 %
Immunizations: Adolescent	92 %	91 %	91 %	91 %	91 %
Immunizations: Childhood	78 %	78 %	78 %	78 %	78 %
Medicare Wellness Visit	78 %	78 %	78 %	78 %	78 %

PSA: Greater Milwaukee ⓘ

	Apr	May	Jun	Jul	MTD
Breast Cancer Screening	78 %	79 %	79 %	80 %	80 %
Colorectal Cancer Screening	80 %	80 %	80 %	80 %	80 %
Diabetes: A1c Control (<8.0%)	72 %	73 %	73 %	74 %	74 %
Diabetes: A1c Testing	76 %	75 %	76 %	76 %	75 %
Diabetes: Nephropathy Monitoring	95 %	95 %	95 %	95 %	95 %
Diabetes: Statin Therapy	85 %	85 %	85 %	85 %	85 %
Hypertension: Controlling High Blood Pressure	82 %	83 %	83 %	83 %	83 %
Immunizations: Adolescent	92 %	92 %	92 %	93 %	93 %
Immunizations: Childhood	78 %	78 %	78 %	77 %	77 %
Medicare Wellness Visit	77 %	78 %	78 %	78 %	78 %

Population Health Index Dashboard: Clinician



- Realtime results
- Color-coded to targets
- Hover to discover features – definitions, drill down to different time frames and levels
- Links to interactive reports (take action in the EMR from the report) at the Department, Clinic, and Clinician level

CULTIVATING A CHAMPION

When Dr. B first started partnering with her Quality Improvement Coordinator, she did not always see the value in some of the measures Quality wanted her to focus on. Medicare Wellness Visits were among the top measures that did not have clinician engagement or buy in at her clinic until Dr. B started to see the impact that the Medicare Wellness Visit could have on helping her provide excellent care and close other care gaps. Dr. B and her LPN are a strong dynamic team who decided to place a focus on Medicare Wellness Visits during the COVID pandemic.

They were able to increase Medicare Wellness Visits in office while still completing virtual and telephone visits. They scheduled and completed over 20 Medicare Wellness Visits a month in both June and July of 2020. Each month, they would work through the Medicare Wellness Visit patient list, performing outreach for those who would be coming due as well as reaching out to patients who were due now. **In doing this, the Medicare Wellness Visit score moved from a 47% in January to a 66% in July and she has continued to improve her score to 80% as of July 2022.** Their hard work and dedication to ensuring that their patients still received excellent care during a very trying time is inspiring.

That wasn't enough for them. They saw the impact their care was having on their patients and started focusing on additional measures. They started to work their diabetic lists to identify patients who were due now or would be coming due in the next month for an A1c. They implemented scheduling the patient's follow-up appointment and future labs before the patient even left the office to ensure that they had a proactive plan in place to continue their diabetic management. Closing care gaps became a driving force with this team and Dr. B wanted to start to implement new clinic practices to help patients live well.

Dr. B's engagement over the last 2 years demonstrates that any clinician can become a champion of quality with the right tools and team!!

Questions

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Appendix

Physician Quality Champion Role

- Leads and champions Primary Care Quality Improvement
- Promotes the commitment to and sense of priority around Quality Improvement
- Serves as an expert and resource to clinicians and operations
- Acts as a role model as demonstrated by surpassing the quality score target
- Meets on a regular basis with Quality Improvement Coordinator(s) to review reports, identify priorities and help develop improvement plans
- Mentors physicians and APCs to identify gaps and opportunities to improve their clinical quality
- Provides feedback and improvement strategies to physicians and APCs with low quality measure scores
- Provides formal education via presentation to physicians, APCs and leaders on quality at Department, Clinic, all provider meetings, etc.
- Shares and develops best practices, workflows, and documentation and EPIC tips for improvement
- Participates in service area and system level meetings with Primary Care Service Line, Quality and Operations leaders

Checklist of MA's

2022 Scheduled Office Visit Workflow Checklist - Items to be reviewed on Children

Identify patient using 2 identifiers	
Document chief complaint and visit format (office/ telephone/ video)	
Review/ update PCP	
Care Team Updated? (annually at well child)	
Vitals completed appropriate to age?	
Smoking status assessed? (12+) User's readiness to quit documented?	
Allergies reviewed?	
Med Rec Done / Mark as Reviewed? / Refills set up?	
Preferred Pharmacy Listed?	
Give handout on MyAurora proxy access if not on portal	
History (M/S/F) Updated/Reviewed? (annually for well child)	
Immunizations WIR/Epic reconciled?	
Document discussion with .HMDiscuss	ASQ at well child ages 9, 18, and 30 months
	Immunizations prepped per unified immunization schedule
	Lead screening 12 months (and at 24 mo at risk/ Medicaid, 3-6 years at risk/ Medicaid if not done previously)
	Anemia screening at 12 months
	MCHAT at well child ages 18- and 24-months
Lipid screening once age 9-11 yr and again 17-21 yr	
Depression screening PHQ 9 12 yr+ annually	
Follow up section states to schedule next appt (well child, chronic or acute follow up)	
Appts / Wait lists made for future labs/chronic & f/u appts?	

2022 Scheduled Office and Virtual Visit Workflow Checklist - Items to be reviewed on Adults

Identify patient with 2 identifiers		
Document chief complaint and visit format (office/ telephone/ video)		
Review/ update PCP		
Care Team Updated? (annually/ MWV)		
Vitals completed (ht, wt, bp) - facility and patient reported		
BP repeat- entered as new set of VS?		
Smoking status assessed? Users Readiness to quit documented?		
Allergies reviewed?		
Med Rec Done / Mark as Reviewed? / Refills set up?		
Preferred Pharmacy Listed?		
History (M/S/F) Updated/Reviewed? (annually for CPE/MWV/preop)		
Advance Directive documented?		
Immunizations WIR/Epic reconciled?- (Reconcile Outside Information)		
Depression screening PHQ2/9 every visit		
Pre-visit Chart Prep/ part of rooming	Review Health Maintenance, Care Everywhere and media tab	Preventive Screening (cancer screening) Wellness visits Chronic disease labs and studies Update external results console
	Order from Screening BPA or from Rooming or Care Gap Smart Set	Cancer screenings, AAA screening, Hepatitis C screening Osteoporosis screening Immunizations (confirm PNA with clinician) Labs for chronic disease management
	Document this discussion with .HMDiscuss	
Diabetes eye exam documents in the chart?		
DM Foot Exam--socks/shoes removed every visit/monofilament available (annually)		
MWV - Clinical staff utilizes appropriate rooming smartset?		
MWV - HRA entered into Smart Chart screening?		
MWV--Vision N2M, Hearing on N2M and Initial		
MWV - LOS states to schedule next MWV?		
MWV - AVS includes Patient Preventative Plan?		
Follow up section states to schedule next appt (preventative, chronic, DM, MWV)		
Appts / Wait lists made for future labs/chronic & f/u appts?		

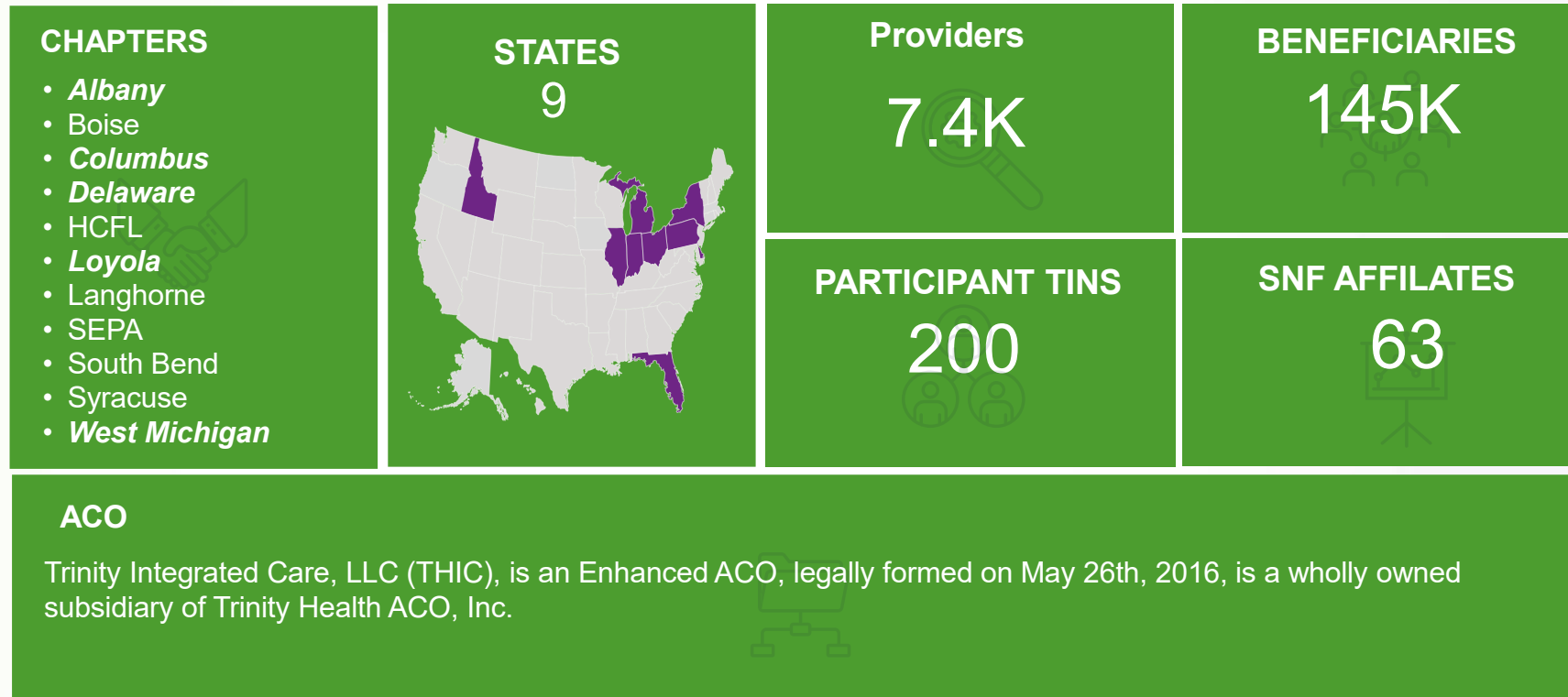


Trinity Health
Mid-Atlantic

Motivating Clinicians for Quality Improvement

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Clinically Integrated Network, PA Region
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September 8, 2022

Trinity Health Integrated Care (THIC)

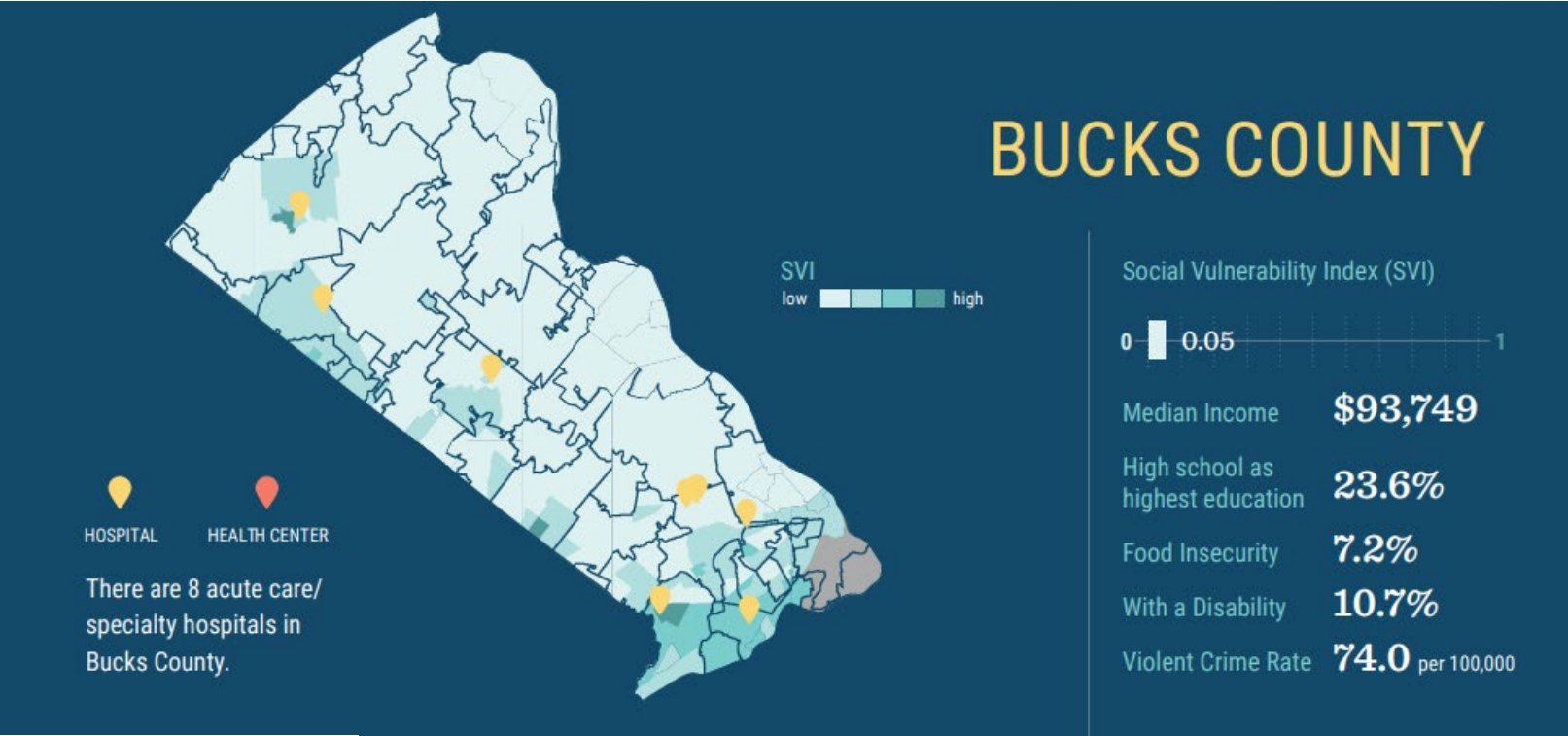


Note: provider and beneficiary counts are estimates



- Chapter of Trinity Health Integrated Care
- Physician led
- Approximately 41,000 attributed lives
- 13,100 MSSP Enhanced Track lives
- Employed and independent practices
- 205 Primary care providers
- 600 Specialists

Population at a Glance



Measure	PY21 Score	Change PY20-21
Diabetes Control	10.53%	- 4.86%
Hypertension	84.62%	9.39%
Breast Cancer Screening	96.00%	8.87%
Colorectal Cancer Screening	92.93%	6.91%

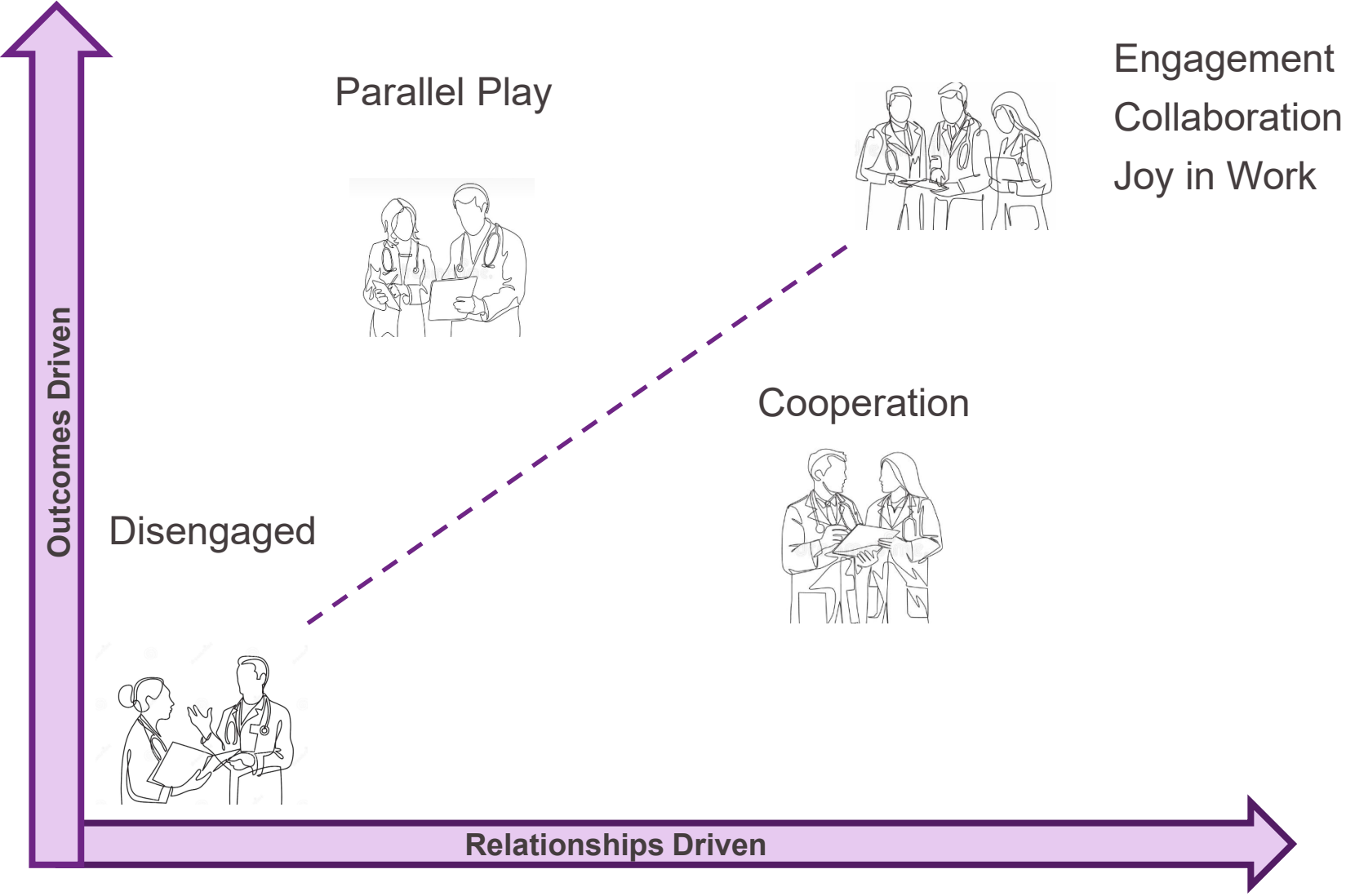


5 of the Web Interface
Measure > 90%

Annual Wellness
Visits 54%

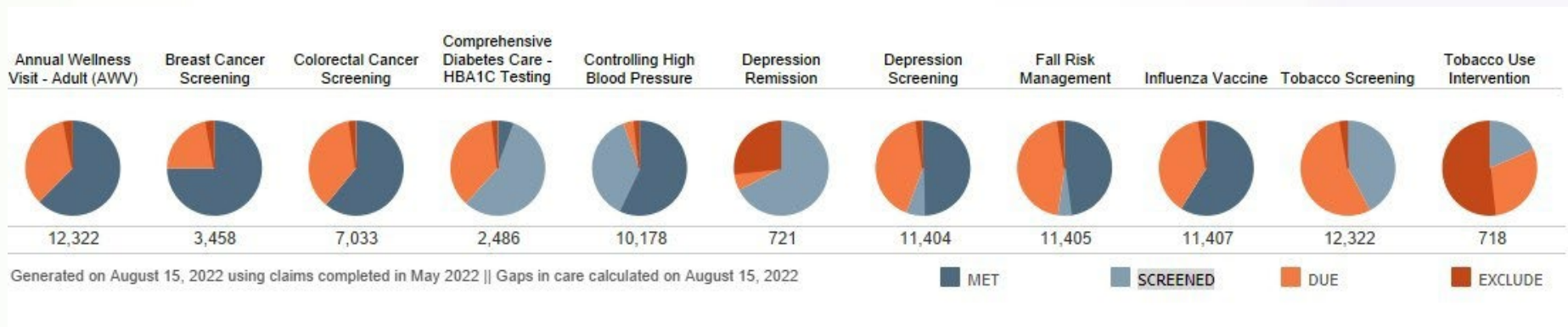
Internal preliminary data for PY2021 – final results pending

Building Engagement & Returning Joy to Work



Quality Team Innovation – Meaningful Data

- Integration of data analytics team & quality team
- Quality reporting portal - AIRMID
- Continuous audit process:
 - Approximately 200 charts per week audited
 - Overcomes claims with no results
 - Allows non-claims based tracking of results
- Individualized **Practice Transformation** action plan



Keys to Successful Clinician Collaboration

- 1) Patient care is priority #1.
- 2) Inter-professional team that extends the reach of the clinician.
- 3) Address social influencers of health that create barriers.
- 4) Connect clinicians to the health system and community based partners.
- 5) Specialist integration and quality improvement.
- 6) Escalate challenges and work across the continuum to deliver solutions.
- 7) Promote clinician well-being and burnout reduction.
- 8) Align incentives.

Go Past Done!

American Heart Association. AMA AMERICAN MEDICAL ASSOCIATION

Measure Accurately Act Rapidly Partner with Patients

Therapeutic inertia CONTROL Diagnostic uncertainty Treatment nonadherence

A1C 5.7-6.4

88 MILLION people have prediabetes.

45 IS THE NEW 50!

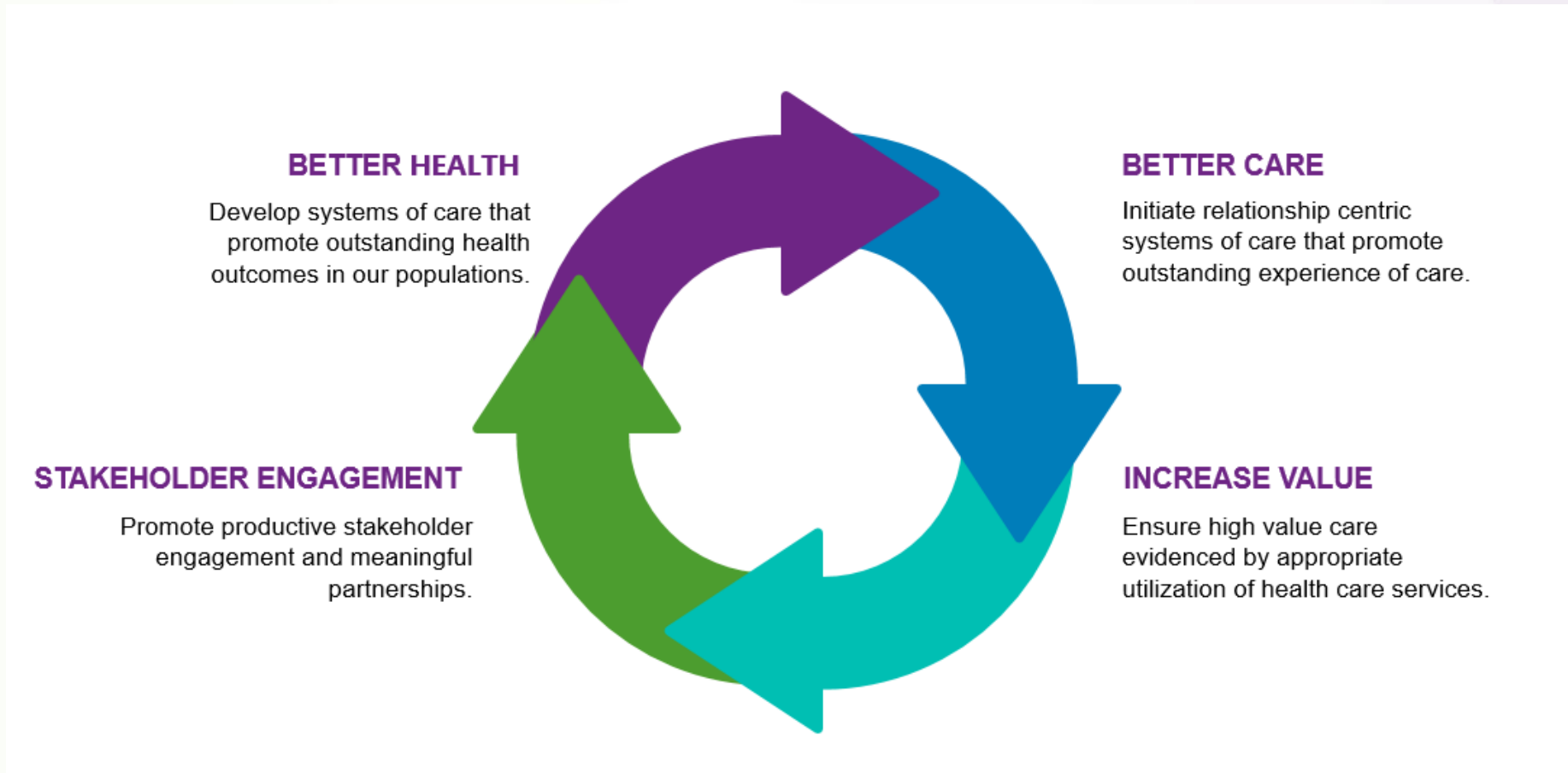
BRING YOUR brave. CDC U.S. Department of Health and Human Services Centers for Disease Control and Prevention

[Colorectal Cancer - American College of Gastroenterology \(gi.org\)](http://gi.org)

[Caring for Young Women Who Are at High Risk for Early-Onset Breast Cancer: A Summary of Screening, Counseling, and Testing Guidelines \(cdc.gov\)](http://cdc.gov)

[Diabetes and Prediabetes | CDC](http://cdc.gov)

Thank you!





**Supporting and Growing
Independent Medicine
in Lincoln, Grand Island,
Hastings, Bellevue, Auburn,
Crete, Holdrege and Kearney**



**Highlight & Share, Don't Rank &
Spank! Motivating Clinicians for QI.**

Bob Rauner, MD, MPH

NAACOS - September 8, 2022



**Supporting and Growing
Independent Medicine
in Lincoln, Grand Island,
Hastings, Bellevue, Auburn,
Crete, Holdrege and Kearney**

- 21 clinic ACO within a 75 clinic IPA
- 21 TIN Commercial ACO - ~35,000 Attributed Lives
- 8 TIN MSSP Track E ACO - ~10,000 Attributed Lives
- Primary Care – FP/IM/OB/Peds including 1 FQHC & 1 Family Medicine Residency Program
- 4 Communities – Auburn, Crete, Grand Island, Lincoln
- Formed in 2016, 1st Contract MSSP January 1, 2017

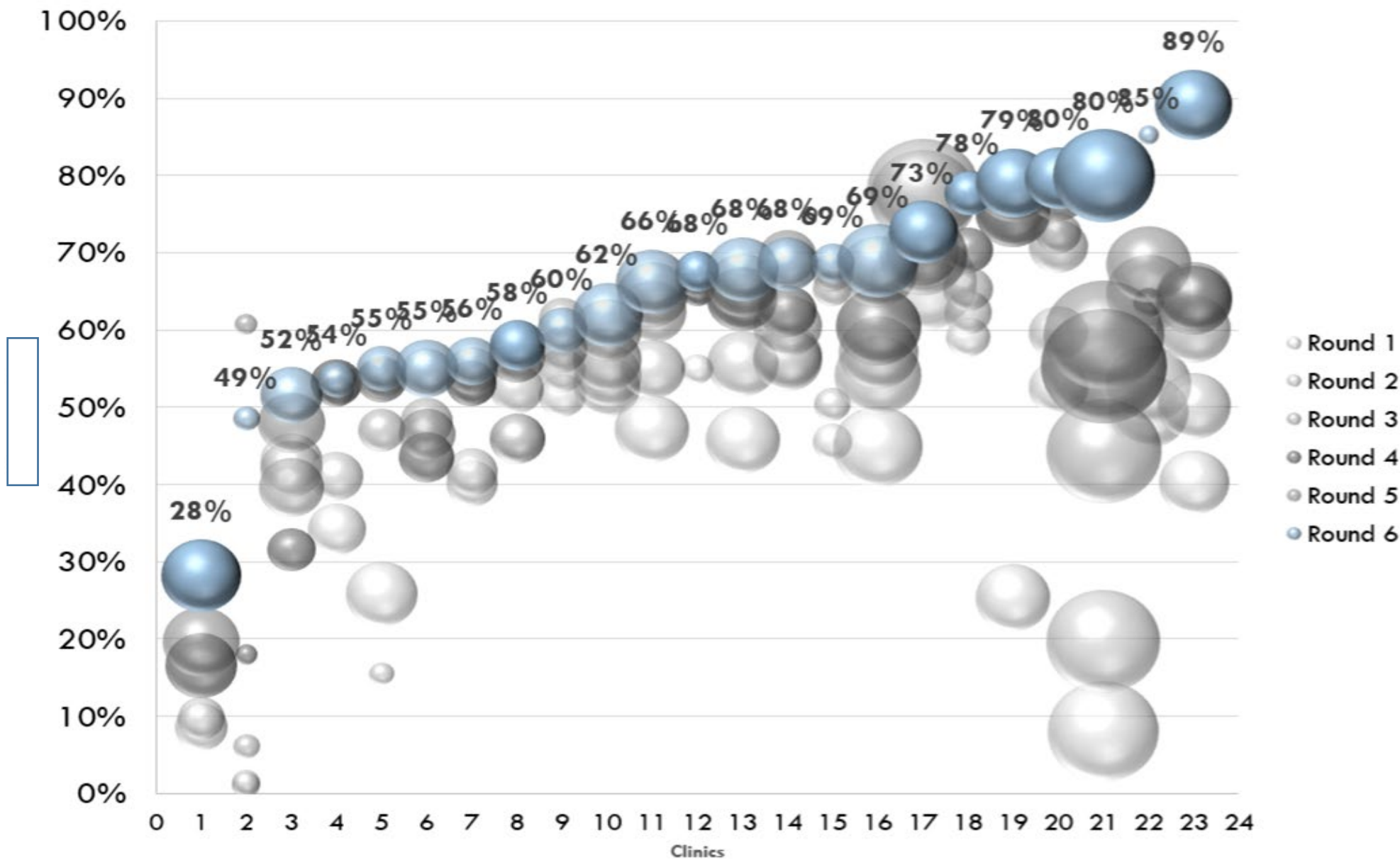


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Crete, Holdrege and Kearney**

MSSP 2021

- Annual Wellness Visits: 83%
- Blood Pressure Control: 82.2%
- Breast Cancer Screening: 84.2%
- Colorectal Cancer Screening: 85.2%
- Diabetes A1c Poor Control: 6.6%
- Per Capita Savings - \$618

Colorectal Cancer Screening



WHY?

5 Whys

It's Just Plain Good
Patient Care

It Improves the Health of
the Entire Community

You Get Style Points If You're
the Best!

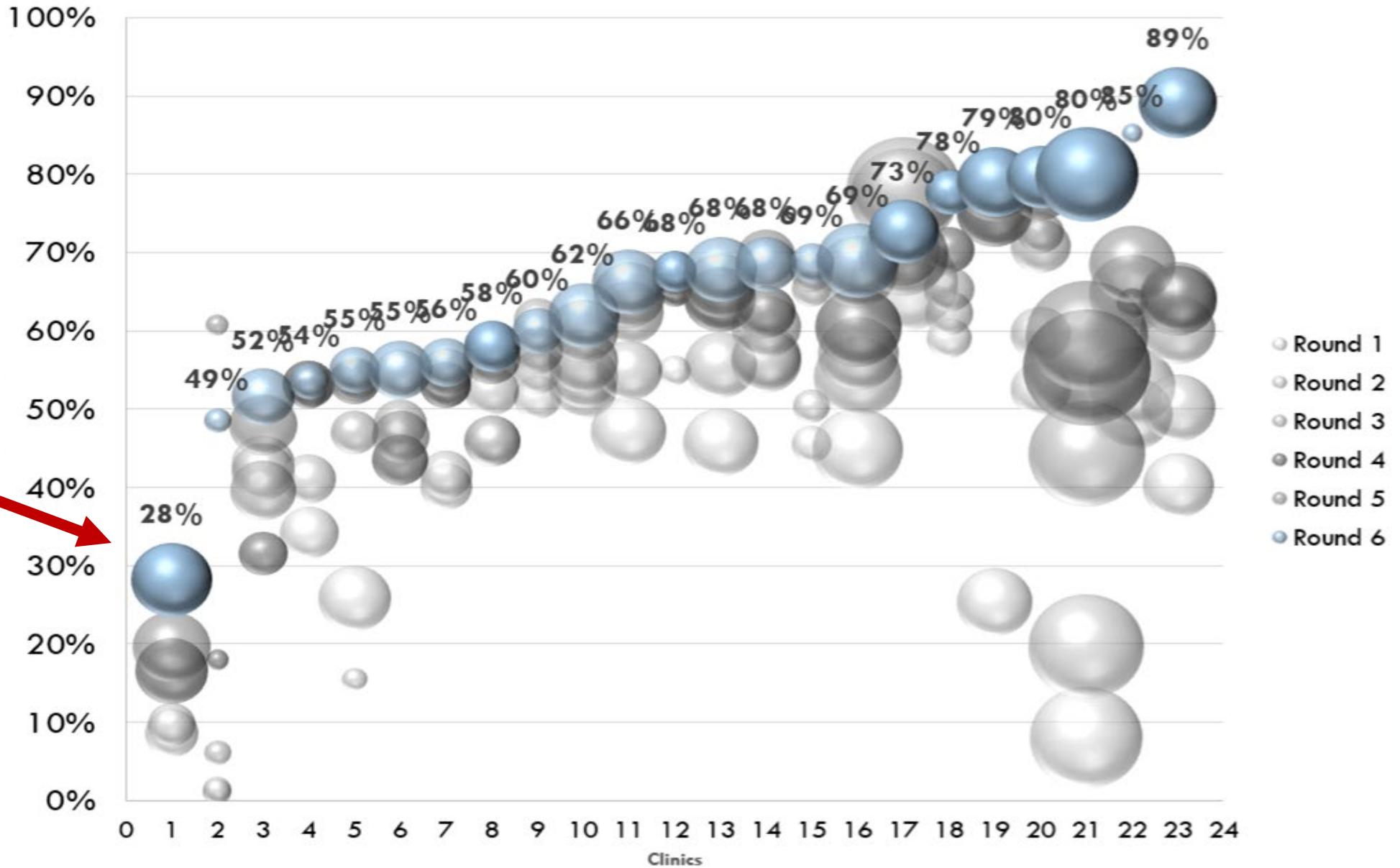
You Can Get Paid Better
On ACO Contracts

30 Hours CME/Part IV MOC

“If you want to build an organization that is fearful, angry, cynical, and full of resistance to change, dump in data without explanation and start ranking and spanking.”

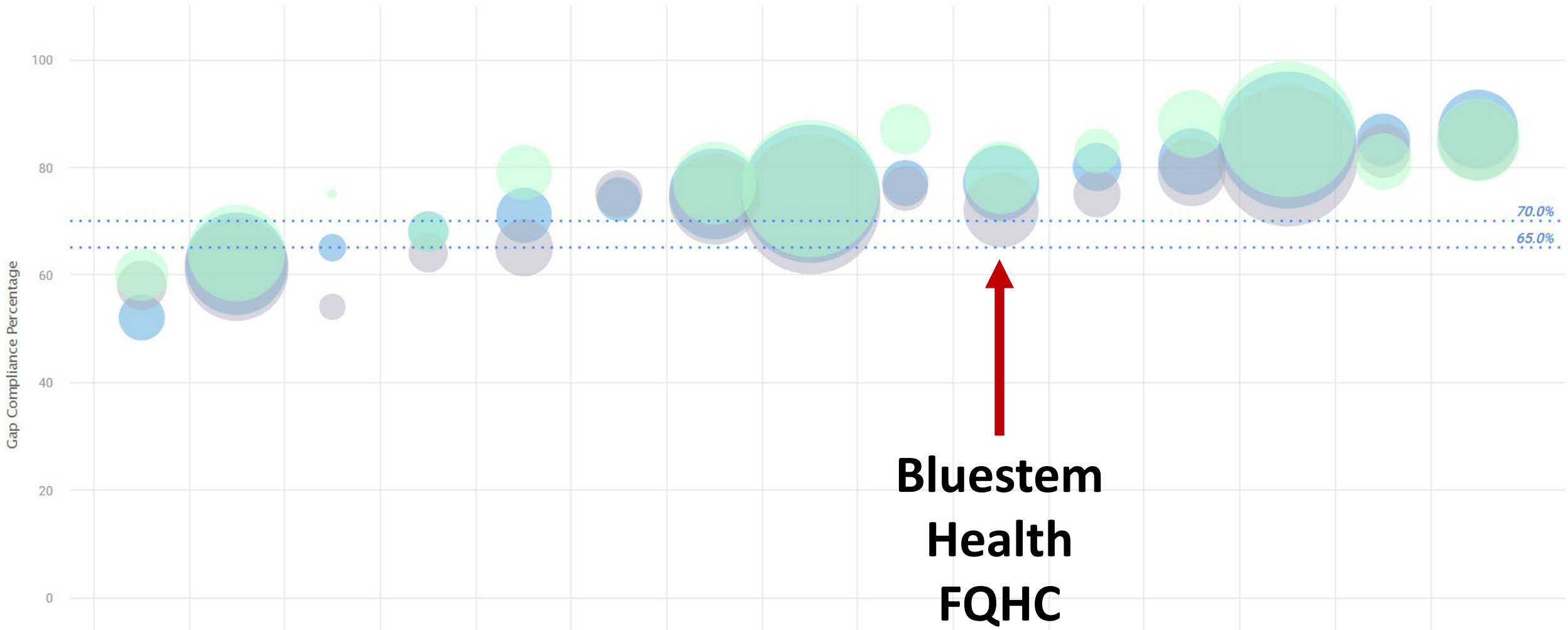
Thom Walsh, Ph.D.

Colorectal Cancer Screening



**Bluestem
Health
FQHC**

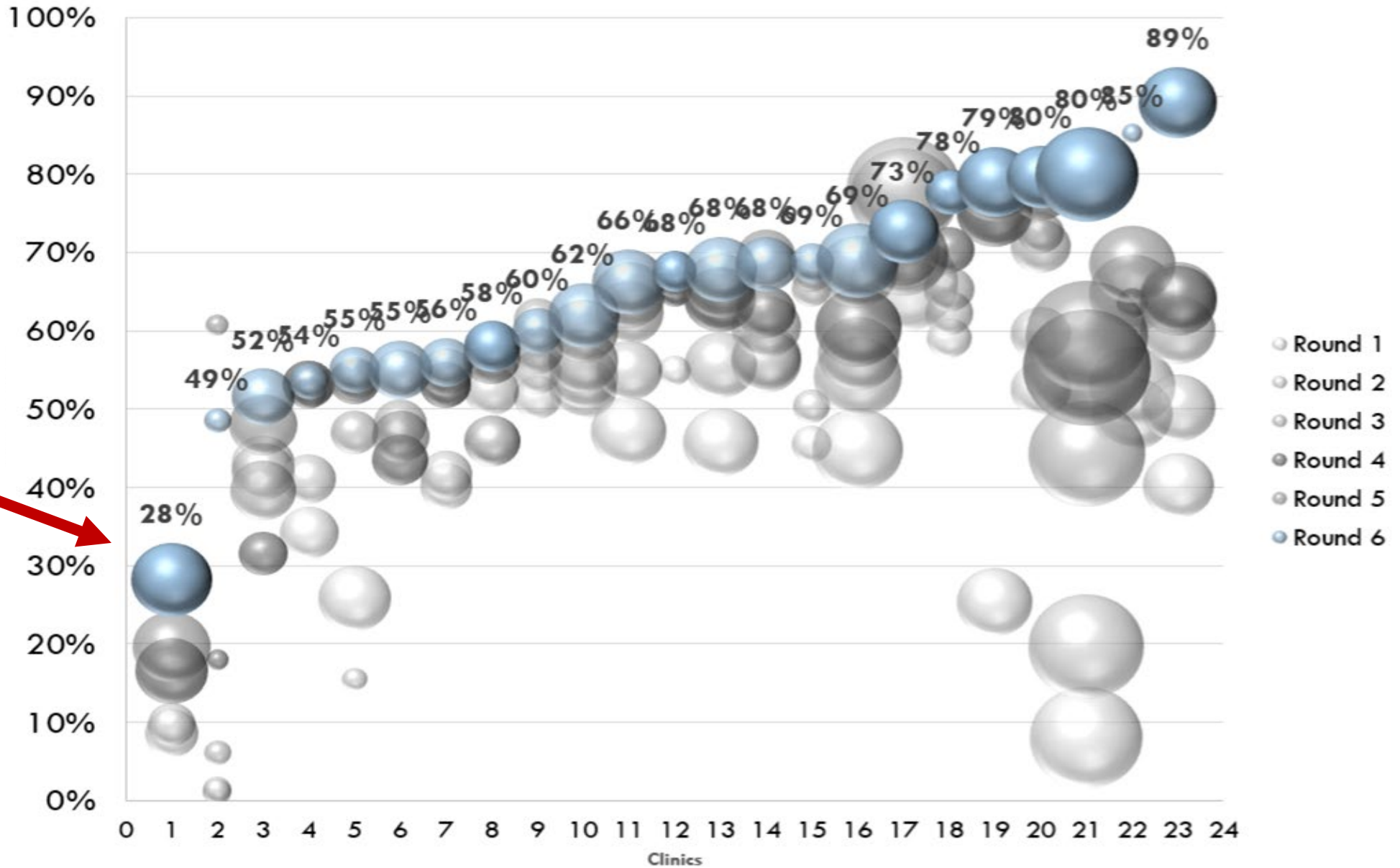




**Bluestem
Health
FQHC**



Colorectal Cancer Screening



**Bluestem
Health
FQHC**





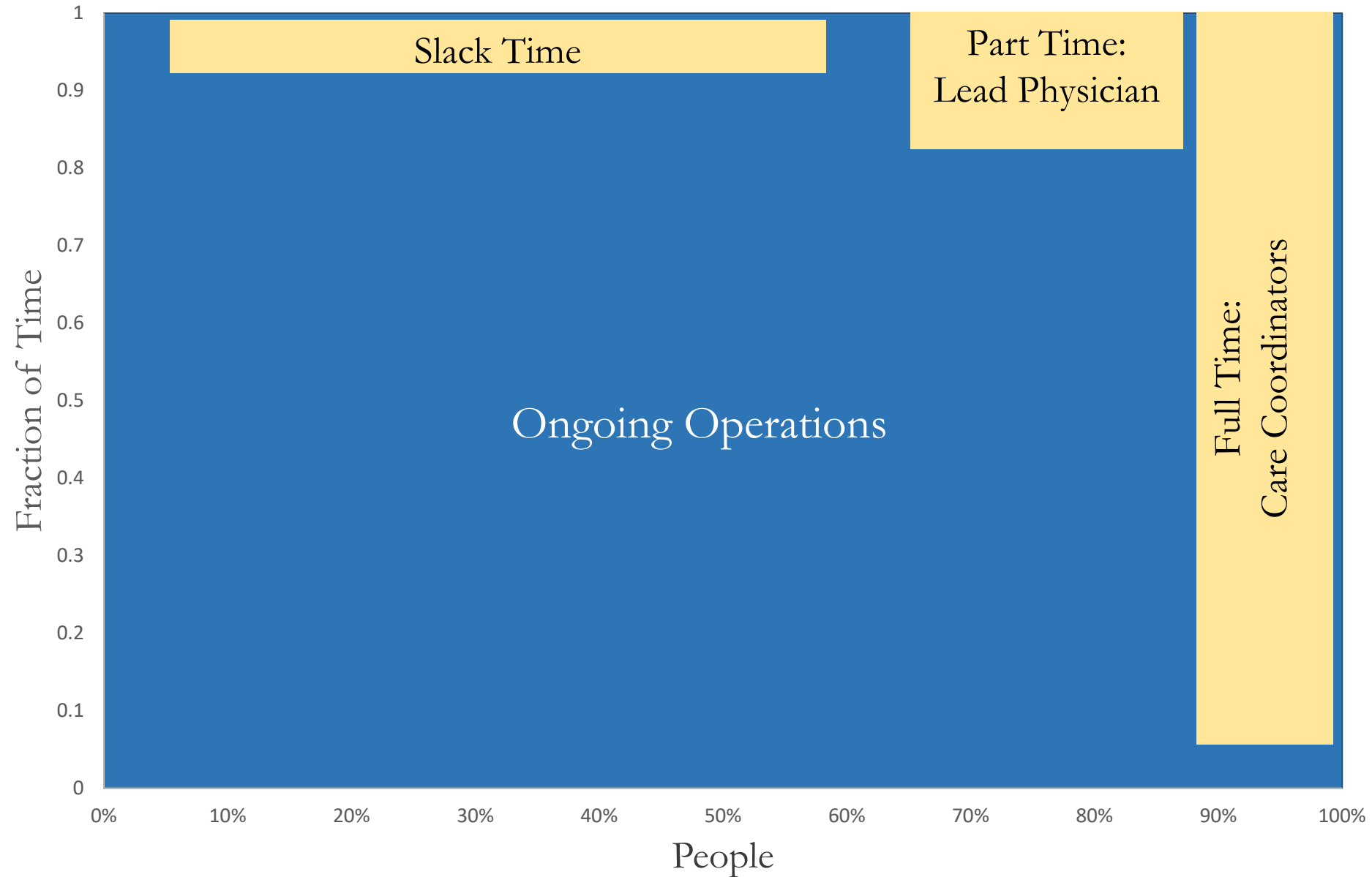
RSA ANIMATE: Drive: The surprising truth about what motivates us

18,850,215 views • Apr 1, 2010

👍 136K 🗨 DISLIKE ➦ SHARE ⬇ DOWNLOAD ✂ CLIP ≡+ SAVE ...

<https://www.youtube.com/watch?v=u6XAPnuFjJc>

Staffing for Quality Improvement



Medicare Primary Care Spend Rate

Cost Per Patient Per Year - \$10,000

$$\begin{array}{rcccl} \text{Fee For Service} & & \text{CPC+ (\$15 PMPM)} & & \text{Shared Savings} \\ \hline 5.5\% & + & 1.8\% & + & 2.3\% \\ & & \text{Total} & & \\ & & \hline & & 9.6\% & & \end{array}$$

Commercial Primary Care Spend Rate

Cost Per Patient Per Year - \$6,500

$$\begin{array}{rcccl} \text{Fee For Service} & & \text{\$4.5 PMPM} & & \text{Shared Savings} \\ \hline 7\% & + & 0.8\% & + & 4.5\% \\ & & \text{Total} & & \\ & & \hline & & 12.3\% & & \end{array}$$



JANUARY 12, 2021

BLOG POST



What Makes Michigan's High-Performing Primary Care Practices Work Well?

MULTIPAYER PRIMARY CARE NETWORK

PRIMARY CARE TRANSFORMATION

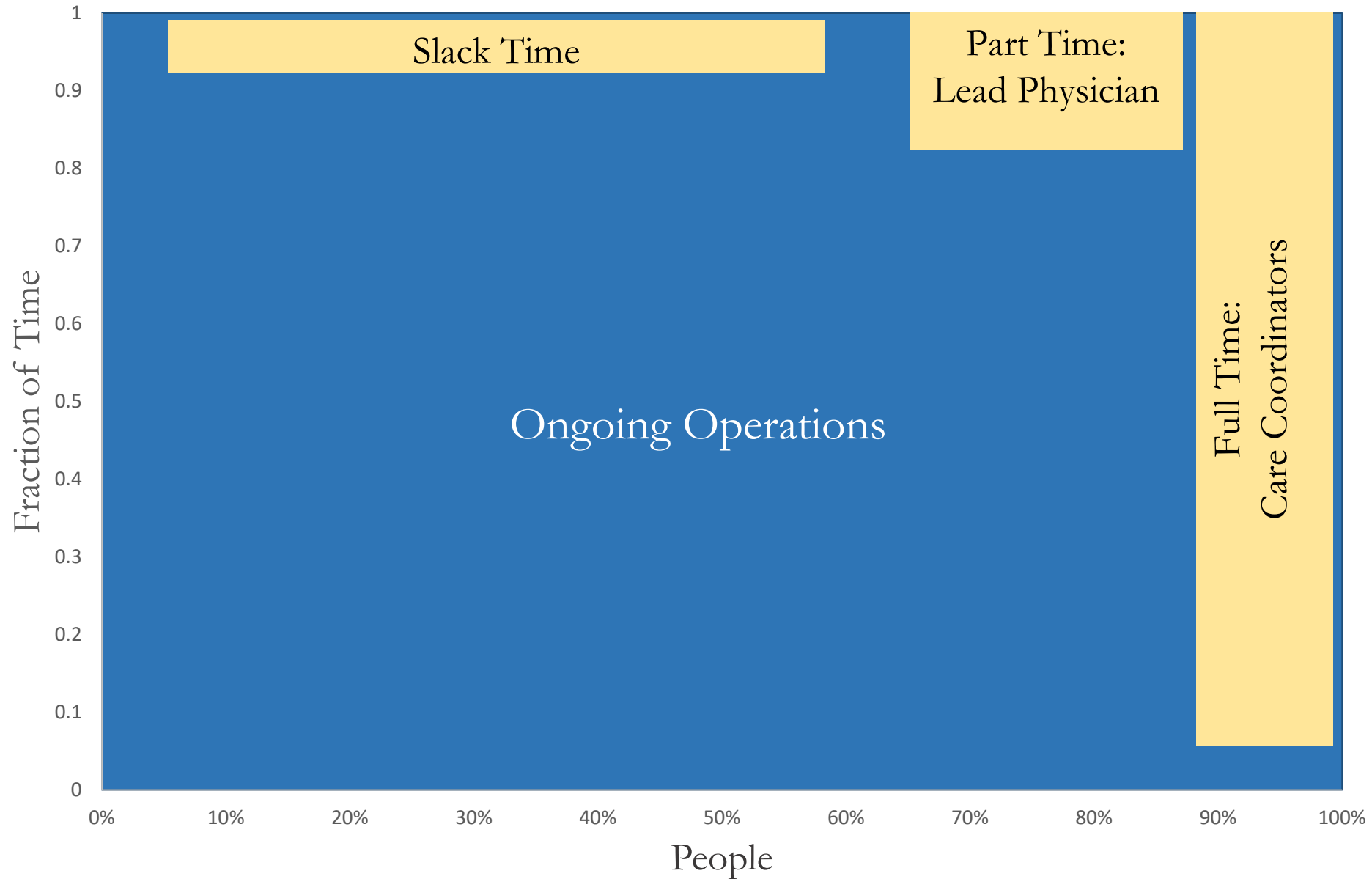
DELIVERY SYSTEM REFORM

- 1. Physician engagement drives patient and practice team engagement and promotes a practice culture that embraces adapting innovations to improve care.** Physician engagement in care delivery reforms drove innovation among all of the high performers studied, regardless of setting (large or small practice; part of a health system or independent). Bay Area Family Physicians, for example, characterized “primary care physician attitude and team championing”

6 Habits of Highly Effective Clinics

1. Physician engagement drives patient and practice team engagement.
2. Co-located (rather than centrally housed) care management greatly improved practices' ability to share information and coordinate team-based care.
3. Offloading routine tasks (e.g., medication refills, gap closures) from the primary care physician workstream frees them to focus on patient needs and championing team-based care.
 - Physicians lead, staff does.

Staffing for Quality Improvement



6 Habits of Highly Effective Clinics

4. Availability and responsiveness to patient needs *as well as patient awareness of the availability* mattered more than extended hours.
5. Integrating performance reporting into regular team huddles or communication drives accountability for performance. Sharing provider-level performance regularly also motivated improvement among individual providers.
6. High-performing practices had a method for identifying patients who would benefit from interventions.

UNABRIDGED



SCALING UP EXCELLENCE

GETTING TO MORE WITHOUT
SETTLING FOR LESS

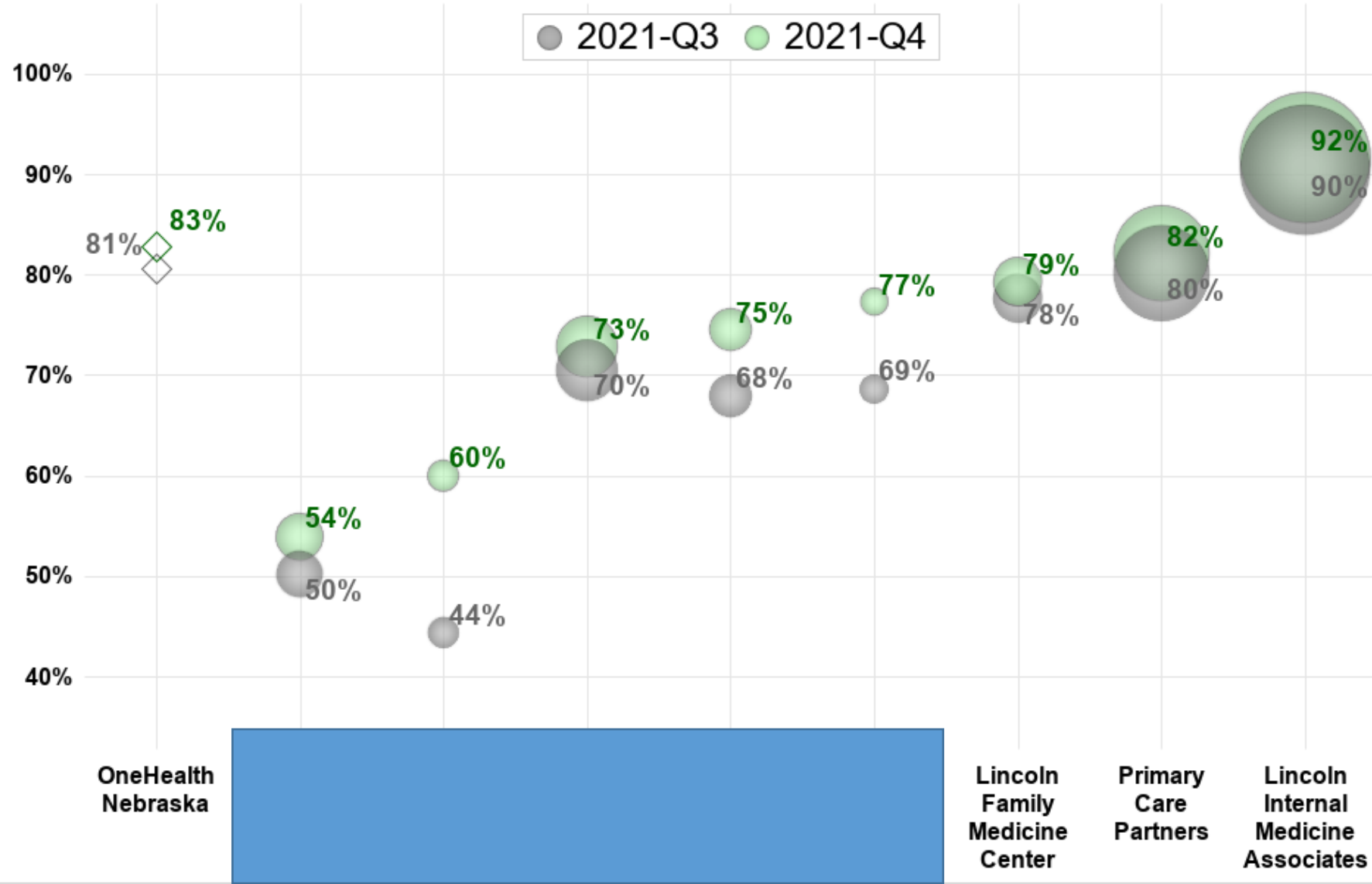


ROBERT I. SUTTON / HUGGY RAO

Catholic vs. Buddhist Approach

Annual Wellness Visit

Claims Paid Thru March 2022



Win/Win/Win

- Patient
- Physicians
- Employers
- Community

3 Most Under-Appreciated Areas

1. Importance of Wellness Visits (AWV in Medicare, WCC in Peds)
2. Primary Care Spend Rate to Insure Necessary Capacity
3. Importance of Continuity, Both Patient/Clinician & Staffing –
 - “Staff Turnover Kills Quality Improvement”



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Questions?

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