TCPI:
Transforming Clinical Practice Initiative

Using Data to Effect Change

Eric Cook-Wiens, MPH CPHQ
KHC Data & Measurement Manager

Mary Monasmith, PCMH-CCE
KHC Quality Improvement Advisor

Compass PTN Learning Community
2016

COMPASS
Practice Transformation Network

KANSAS MEDICAL SOCIETY

Kansas Healthcare COLLABORATIVE

1

National Quality Strategy

- Three-part Aim
- Six Priorities
- Nine Levers
- Stakeholders

2

Pursue three aims at the same time

3

Six Priorities

Priority 1: Making care safer by reducing harm caused in the delivery of care

Priority 2: Ensuring that each person and family members are engaged as partners in their care

Priority 3: Promoting effective communication and coordination of care

4

Six Priorities (cont.)

Priority 4: Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease

Priority 5: Working with communities to promote wide use of best practices to enable healthy living

Priority 6: Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models

5

Nine Levers

6

IHI Triple Aim and NQS Three Aims

Improving the health of populations

Reducing the per capita cost of health care

Better Care: Improve overall quality, by making health care more patient-centered, reliable, accessible, and safe.

NATIONAL QUALITY STRATEGY

Healthy People/Healthy Communities: Improve the health of the U.S. population by supporting proven interventions to address behavioral, social and, environmental determinants of health.

Affordable Care: Reduce the cost of quality health care for individuals, families, employers, and government.

From Slide Set: National Quality Strategy Overview
www.ahrq.gov/workingforquality/toolkit.htm (accessed 4/21/2016).

8

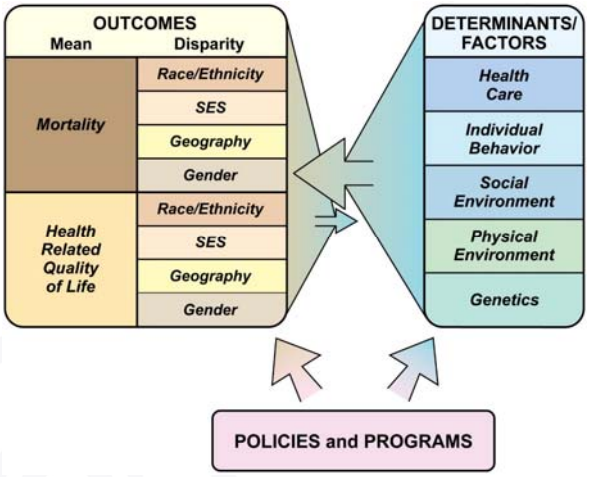
Healthy People/Healthy Communities

Two terms need to be unpacked:

- Determinants of health
- Population health

8

Defining Population Health



Population Health
The health outcomes of a group of individuals, including the distribution of such outcomes within the group.

Evans and Stoddart Field Model as modified by Kindig.
www.improvingpopulationhealth.org/blog/what-is-population-health.html (accessed 4/18/2016)

9

Defining Population

Health Improvement Activities
"Population Management" or "Population Medicine" generally means design, delivery, and coordination of and payment for health care services for sub-populations.
Still oriented toward Triple Aim – but from the perspective of the health care industry.

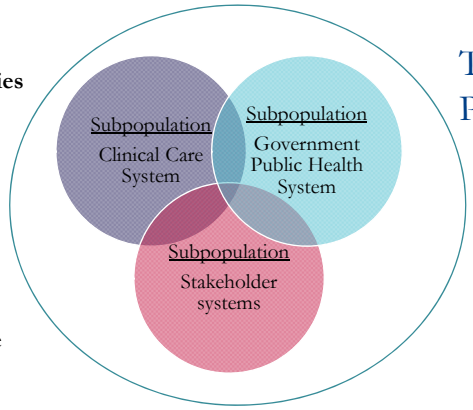


Figure adapted from Jacobson and Teutch. (2012). An environmental scan of integrated approaches for defining the measuring of total population health by the clinical care system, the government public health system, and stakeholder organizations.

10

Tension between Population Management and Total Population Health

Certain sub-populations, often the most complex and costly patients, require comprehensive care designs that address the determinants of total population health.

- **High risk**
- **Vulnerable populations**
- **Rising risk**

Sometimes, the needed health intervention is outside the domain of the health system.

11

Health Systems and Public Health are Natural Allies

- Clinical care impacts population health
  - The quality of care impacts population health
- Health systems have growing accountability for the health outcomes of their patients (sub-population)
- To impact health outcomes, the determinants of health must be addressed
- Many of the determinants of health are not in the clinical domain
- **We are all accountable for total population health**

12

Healthcare and Public Health are Natural Allies

- Kansas Department of Health & Environment is working to impact total population health
  - 1305
  - 1422
  - Million Hearts
- Engagement with health systems is one component of a broad strategy
- Opportunities for PTN
  - Evidence-based interventions in the community
  - Strengthen linkages between health care systems and community-based resources to impact the determinants of health
  - New Partnerships

13

Population Health Tool Set

- Population health improvement is driven by data
- Tools for population health:
  - Assign to panels
  - Assign accountability
  - Stratify risk (informed by the determinants of health)
    - High risk
    - Vulnerable populations
    - Rising risk
  - Identify risk factors which may progress to preventable medical conditions
  - Develop registries
  - Identify care gaps
- Accurate reporting depends on reliable documentation

14

Measurement Strategy

- Your data is your data, not ours
- Don't look at data as a reporting burden, look at it as a tool set to develop
- Transformation will require:
  - Learning new data-related skills
  - Learning about standard quality measures

For the PTN to evaluate itself, it needs data too

15

Compass PTN Measures Menu

Outcome Measures:

- Diabetes: Hemoglobin A1c Poor Control (PQRS 001)
- Controlling High Blood Pressure (PQRS 236)
- All-Cause 30-day Readmission Rate

Process Measures/ Efficient Use of Health Resources:

- Use of appropriate medications for asthma (PQRS 311)
- Heart Failure Beta-Blocker therapy for LVSD (PQRS 008)
- Use of Imaging Studies for Low Back Pain (PQRS 312)
- Appropriate Treatment for Children with Upper Respiratory Infection (PQRS 065)
- Overuse of diagnostic imaging for uncomplicated headache (Choosing Wisely)
- Overuse of diagnostic imaging for simple syncope (Choosing Wisely)
- Avoidance of Unnecessary Use of CT in Immediate Evaluation of Minor Head Injury (CW)
- Overuse of Diagnostic Imaging for Uncomplicated Sinusitis (Choosing Wisely)

Communication and Care Coordination

- Closing the Referral Loop: Receipt of Specialist Report (PQRS 374)

Patient Safety

- Documentation of Current Medications in the Medical Record (PQRS 130)

16

Choosing Wisely®

- An initiative of the ABIM foundation
- Initiative to address waste in health care and avoid risks associated with unnecessary treatment
- Over 70 Medical Specialty Societies submitted recommendations of overused tests and treatments

For more information: www.choosingwisely.org

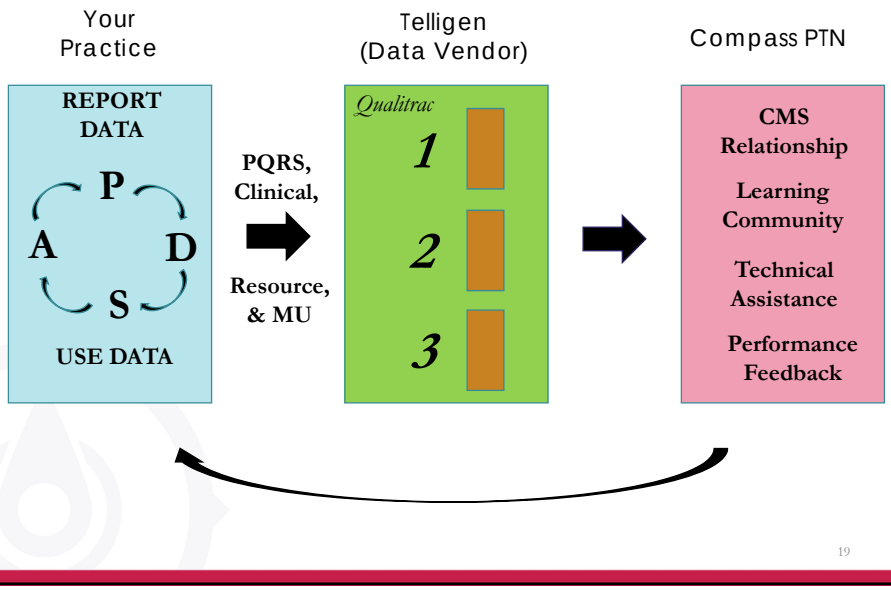
17

Compass PTN data system

- Web portal developed by Telligen
- Aggregate monthly numerator and denominator
  - Entered by hand or through QRDA Type-3 file
  - Optional patient-level tracking for clinics without EHR
- Performance improvement plan
- Technical Support from Telligen and through your quality improvement advisors
- Evolving:
  - Kansas Healthcare Collaborative is committed to building a sustainable data system to support quality improvement for Kansas hospitals and providers

18

Compass PTN Data Flow



19

Compass PTN measurement

- Remember, this is a skill set
- Work with improvement advisors to identify measures that are a priority for your organization
  - At least one from the core list
- PQRS 2016 measure list: **284 measures** including specialties
- National Quality Forum measure clearinghouse

  www.qualityforum.org

20

Baseline Data

- Demographic analysis
- Meaningful use
- Clinical quality measures

21

NQF 0059

- Diabetes: Hemoglobin A1c Control
- Percentage of patients 18-75 years of age with diabetes who had a hemoglobin A1c>9.0%

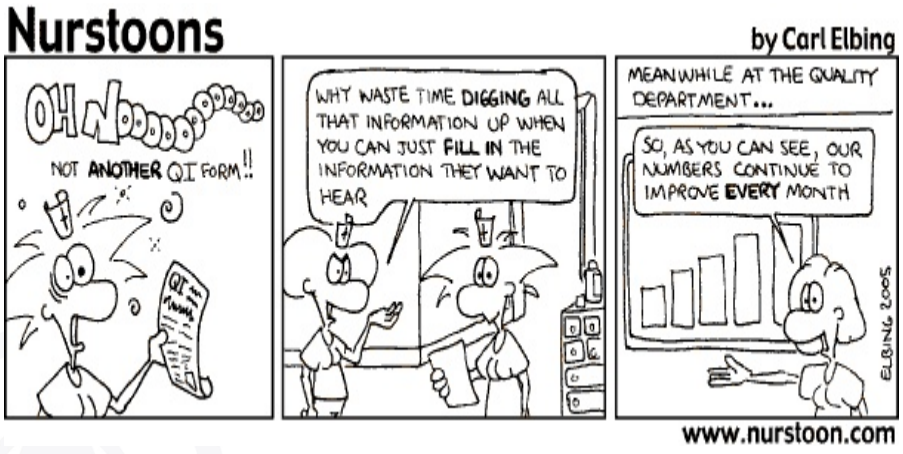
22

NQF 0018

- **Controlling High Blood Pressure**
- Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period.

23

Make it Meaningful



24

Party

25

Cost of Care

- QR/UR report
- Attributed beneficiaries and total costs

26

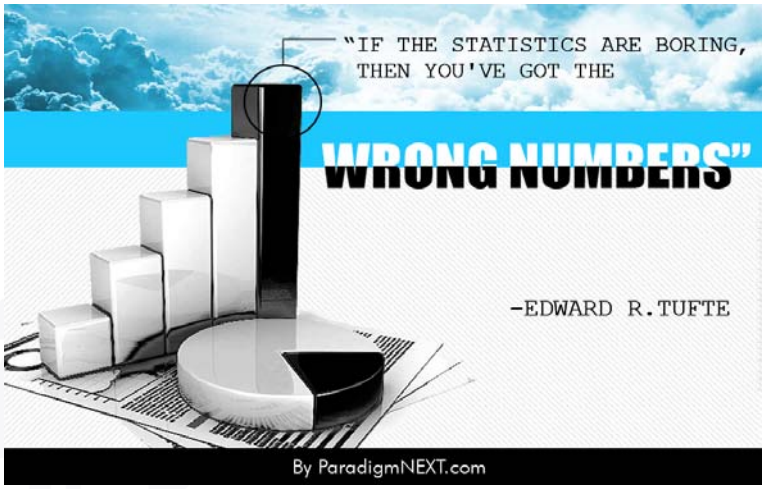
Relative Weights of MIPS Components

	2019	2020	2021	2022
Quality (PQRS)	50%	45%	30%	30%
Resource Use	10%	15%	30%	30%
MU*	25%	25%	25%	25%
Clinical Process Improvement	15%	15%	15%	15%
Reward/Risk	+4% to -4%	+5% to -5%	+7% to -7%	+9% to -9%

Source: The Medicare Access & CHIP Reauthorization Act of 2015.

27

Summary



28

Thank you

Kansas Healthcare COLLABORATIVE

Eric Cook-Wiens
Data and Measures Manager
Kansas Healthcare Collaborative
ecook-wiens@khconline.org
(785) 235-0763

Mary Monasmith
Quality Improvement Advisor
Kansas Healthcare Collaborative
mmonasmith@khconline.org
(785) 230-9742

29

COMPASS Practice Transformation Network

KANSAS MEDICAL SOCIETY

Kansas Healthcare COLLABORATIVE

30