

ACO: Be in the Know

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Welcome to the first edition of the Western Maryland Physician Network provider newsletter, "ACO: Be in the Know" - a monthly publication that will provide important updates, reminders and key information to keep our practices up to date.

• GPRO: Thanks to everyone for making our first GPRO submission a success!

Quality Measure Benchmarks for reporting for PY2016 indicate that we need to reach at least the 30th percentile on at least one clinical performance measure in each of four domains to be eligible for shared savings in PY2016. All 33 measures from PY2015 will be present for PY2016 GPRO reporting plus the addition of a statin therapy measure.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Results:

The three ACO CAHPS slides (below) from HealthStream show results from 2015 and action plan for 2016 areas for improvement ([Click on each slide for a larger pdf version](#))

Top 3 Priorities ACO-CAHPS

Western Maryland Physicians Network, LLC (N=403)

Measure	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Provider Clear Information	42	77.4%	12	11	19%	80.7%					
Clear Communication by Provider	22	77.4%	1	1	1%	87%					
Provider Likeness/Confidence	24	82.3%	14	11	13.5%	88.4%					
Provider Overall Rating*	100	74.2%	14	11	13.8%	84.3%					

* Please note this table is unweighted.

Best Practices

Clear Communication by Provider

- Consider patient needs, with perspective and individual experience.
- Review with the patient what they made an appointment, details explain your understanding of the visit, the day, the time, the location, etc. - not for the patient to confirm before further consultation.
- Confirm with the patient's purpose for making the appointment.
- Continue with consultation based on patient needs and physician assessment.

Offering patient opportunities to provide input and participate in their care

- Ask the patient what the goal is for their visit and explain their goals, objectives.
- Discuss the information that makes the goal attainable or not.
- Ask the patient if they got what was needed.
- Consider with a partner or with the patient needs or objectives, what the patient's goal was for the appointment, which actions are necessary to be completed before the next appointment, and/or the patient's or the physician's.

Provide Care Information

- Providing a great experience to patients using language that they understand.
- Repeat that step in the patient's care with the performance opportunities how long with each one, additional people they will meet (e.g., respiratory therapist, CT technician, consultant, etc.) or drug needed procedure (specify instructions, etc.) and/or other needs.
- Final and/or procedure results are completed during the visit, explain all findings.
- Repeat the three elements of their plan of care, what is the diagnosis or status of their condition, what is the proposed treatment and what follow-up they need.
- Use language patients can understand. Avoid using any medical jargon.

Best Practices

Provider Likeness/Confidence

- Set Goals
- Initial perception of this visit's quality
- Clear Attention
- Communicate to the listening, reflecting back, and give contact.
- Active listening in the context of a quality partnership, active listening is important to justifying this and showing it is a method of giving patient's input and building the therapeutic bond.
- Reducing back has two benefits: it helps clarify what we need, and it shows the patient that we care enough to want to understand. The physician, CarePages, founder or client-centered therapy, indicates that the caregiver report is "value-based" and has been shown to the patient. It shows that they are heard and understood.
- Eye Contact - Shows empathy, asks someone across the room, that they have our attention by making eye contact.
- Slow and Simple Explanation.
- Speak in a slow and deliberate manner.
- Give patients the time they need to comprehend the information. Start the visit by engaging in long, open-ended questions that give patients the opportunity to ask questions and establish a dialogue with providers.
- Questions also give us a good indication of how well the patient comprehends what's being said.

Measure	Description	2015 Measure Rate (%)	2015 Premier SPRINT Percentile	2015 CMS Type	2016 Type	2017 Type
CARE-2	Falls Risk Screening	26.9%	62.7%	40th	R	30th
CARE-3	Medication Reconciliation	67.8%	84.3%	Not Set	R	Not Set
CAD-7	ACE Inhibitor or ARB therapy for patients with CAD and Diabetes and/or LVSD	84.7%	79.0%	70th	R	70th
LVSD-2	Diabetes: HbA1c in poor control >9 or missing	33.4%	14.1%			
DM-7	Diabetes: Eye Exam	31.3%	41.4%			
DM-COMP	Diabetes Composite	13.7%	37.3%	Not Set	R	Not Set
HF-6	Beta Blocker therapy for LVSD	54.9%	86.6%	50th	R	50th
HTN-2	Controlling High Blood Pressure	65.7%	69.9%	50th	R	50th
IND-2	Ischemic Vascular Disease: Use of Aspirin or another Antithrombotic	89.1%	88.2%	80th	R	80th
WH-1	Depression Remission at Twelve Months	0	0.0%	Not Set	R	Not Set
PREV-5	Breast Cancer Screening	51	68.9%	50th	R	50th
PREV-6	Colorectal Cancer Screening	43.87	61.80	40th	R	40th
PREV-7	Influenza Immunization	44.59	68.7%	40th	R	40th
PREV-8	Pneumonia Vaccination for Older Adults	47.08	70.1%	40th	R	40th
PREV-9	BMI Screening and Follow-up Plan	61.2	71.3%	60th	R	60th
PREV-10	Tobacco Use Screening and Cessation Intervention	84.92	93.3%	80th	R	80th
PREV-11	Screening for High Blood Pressure and Follow-up Documented	43.37	76.0%	40th	R	40th
PREV-12	Screening for Clinical Depression and Follow-up Plan	24.32	46.0%	60th	R	<30th

(17 Clinical measures GPRO PY2015 performance vs PY2016 goals)

Choosing Wisely:



Dr. Steve Smith
 Medical Director

In the evaluation for a simple syncope and a normal neurological examination, don't obtain brain imaging studies (CT or MRI).

American College of Physicians

Care Coordination:

Community Care Coordination is working with approximately 130 high-risk, complex patients. Examples of Care Coordination interventions include: disease education, med reconciliation, arranging transportation, advance directive completion, and assisting with financial needs.

Practice Name	Attributed Medicare Beneficiaries		JH ACG Risk Score	PM Cost	IP Admission Rate/1000	Annual Medicare Wellvisit Rate	30 Day Readmission Rate %	Emergency Room Visit Rate / 1000
	2015	2015	2015	2015	2015	2015	2015	2015
Practice 1	15	2.37	\$1,698.00	467.92	13%	28.57%	1537.47	
Practice 2	68	1.72	\$1,445.00	486.6	85%	12.12%	1,135.41	
Practice 3	678	1.36	\$1,520.00	368.77	83%	22.28%	448.11	
Practice 4	1005	1.88	\$1,676.00	625.56	20%	16%	856.83	
Practice 5	92	6.75	\$558.00	141.69	0%	0.00%	281.46	
Practice 6	670	2.07	\$2,824.00	797.67	22%	20.42%	764.74	
Practice 7	257	2.03	\$2,325.00	827.13	16%	19.81%	987.69	
Practice 8	1506	1.31	\$1,036.00	339.91	60%	14.80%	446.53	
Practice 9	315	1.17	\$726.00	276.93	6%	14.84%	477.47	
Practice 10	3705	1.39	\$1,487.00	479.56	25%	17.49%	735.64	
Practice 11	33	1.85	\$1,372.00	546.92	15%	16.67%	607.69	
Practice 12	22	1.77	\$1,678.00	820.39	14%	5.56%	2324.43	
Practice 13	100	1.2	\$774.00	217.25	23%	11.54%	710.24	
Practice 14	1009	1.39	\$919.00	306.08	53%	14.29%	393.53	
Total/Average	8995	1.57						
CMS Quarterly Data			\$ 1,027.00					
Goal			\$1,011	294/1000			335/1000	
Meeting goal				Millman			Millman	
							Not meeting goal	

* This represents the total distinct count of patients that were cost in the ACO during the specified timeframe.



An initiative of the ABIM Foundation

Patient Centered Medical Home (PCMH)

We are pleased to announce that after a year of data gathering, quality improvement efforts with improvements and many transformations, the following three practices from our ACO (WMPN LLC) have achieved the esteemed recognition of a Level 3 Patient Centered Medical Home (PCMH): **South Cumberland Primary Care**, 1050 Industrial Bld.; **LaVale Primary Care Center**, 1313 National Hwy; and **Dr. Shakil/Dr. Naeem Primary Care**, 625 Kent Ave.

These offices experienced many transformations within the year to include appointment availability. This was accomplished by adopting new office hours starting as early as 7 a.m. and remaining open until 7 p.m. along with offering Saturday appointments. The providers came together as a team to provide 24/7 access for their patients by forming an on-call group. This allows their patients to contact a provider after hours and weekends to seek medical advice. Another key component to this success was the integration of care coordination and behavioral health services into each practice.

This recognition is awarded by NCQA which is a private, non-profit organization dedicated to improving health care quality. NCQA recognizes the vital role clinicians play in advancing quality patient care. The Recognition Program assesses whether clinicians and practices support the delivery of high-quality care and are built on evidence-based, nationally recognized clinical standards of care.

We are dedicated to being patient-centered and giving our patients high quality, evidenced-based healthcare. If you and your staff would like to join us to achieve this esteemed recognition, please contact **Karen Ullery, Supervisor of Clinics and Practices**, at **240-964-8265**.

Upcoming CMS and Premier webinars & conference calls:

CMS - Designing Data Reports for Practitioners

Date: May 19, 2016

Time: 2:30 - 4 p.m. (Eastern time)

Please contact Debbie Mullaney at 240-964-8267 for more information.

Quality Performance/Clinical Measures

Measures of the Month

Each month we will focus on a few of the clinical measures and items for quality performance for the ACO. These measures and guidelines are what every ACO must document for assessment of compliance with the ACO directives. This month's focus will be on two Clinical Measures: **MH-1 Depression: Remission at 12 Months** and the new **PREV-13 Statin Therapy for the Prevention and Treatment of Cardiovascular Disease**.

Depression Remission: The Depression Remission measure for PY2016 needs to have the diagnosis of major depression or dysthymia (whether new or existing) and an initial PHQ-9 score greater than 9 documented in the medical record between 12/1/2014 and 11/30/2015 for all patients 18 or older with Medicare insurance who do not reside in a nursing home or receive palliative care/hospice. A follow-up score of less than 5 on the PHQ-9 must be documented in the EMR at 12 months from the index date (+/- 30 days) (per CMS guidelines).

New Statin Therapy: The new Statin Therapy measure for PY2016 looks at patients age 21 or older who were previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD) **OR** have a fasting or direct low-density lipoprotein cholesterol (LDL-C) level \geq 190 mg/dL **OR** patients aged 40-75 with a diagnosis of diabetes (type I or II) with a fasting or direct LDL-C level of 70-189 mg/dL anytime in 2013, 2014, or 2015. Patients who are exempt from this measure are those that have an allergic reaction to statins, those receiving palliative care, patients with end-stage renal disease, patients with hepatic disease or impairment, or patients with diabetes that are not on statin therapy. (Statin must be documented in EMR medication list as an active medication within the measurement period.)

Reports & Dashboards

Premier has identified several areas for improvement within the ACO that should move WMPN into better standing with comparable ACOs. WMHS is actively reviewing patients with high utilization of ED visits, Part B Medicare drug spend, high cost imaging utilization, and Medicare Wellness Visit coding/appointments. WMHS has already implemented a MWV protocol by hiring dedicated LPNs to schedule and see patients for these visits.