TRANSFORMING CLINICAL PRACTICE INITIATIVE

Results from Maryland Practices in the Garden Practice Transformation Network

September 2020

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Background

The Centers for Medicare & Medicaid Services (CMS) Transforming Clinical Practice Initiative (TCPI) began in September 2015 and concluded in September 2019.[1] TCPI aimed to help health care providers be successful under the new Quality Payment Program, part of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). TCPI provided hands-on support to practices for developing skills and tools needed to improve care delivery and transition to alternative payment models (APMs). It was one of the largest federal investments uniquely designed to support clinician practices via nationwide, collaborative, and peer-based learning networks that facilitate large-scale practice transformation[2].

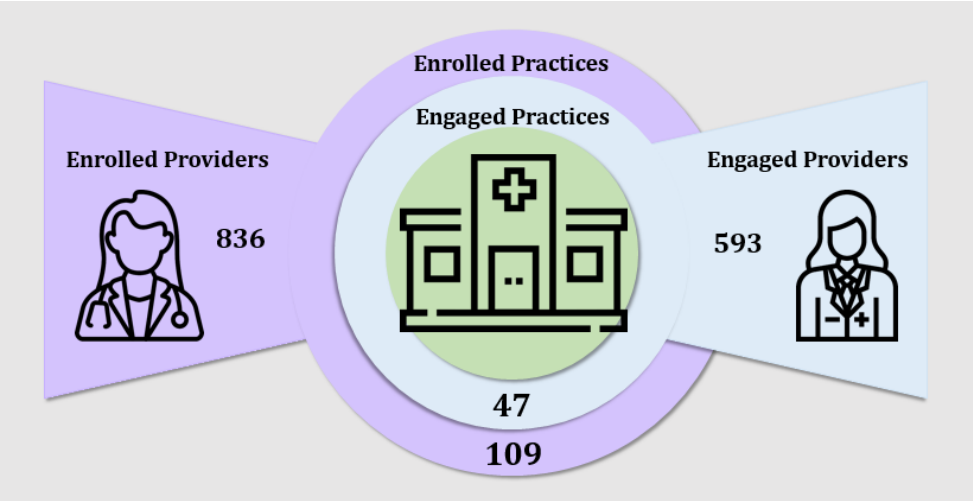
Under TCPI, grantees aimed to expand quality improvement capacity, engage in greater peer-to-peer learning, and utilize health data to determine gaps and target health care interventions. TCPI grantees formed practice transformation networks (PTNs) to support primary care and specialty practices through peer-based learning to achieve health care transformation, prepare to successfully participate in value-based payment arrangements, and improve care quality. PTNs were designed to coach, mentor, and assist health care providers in developing core competencies specific to practice transformation, such as improving patient care, organization, and workflow. In 2015, the New Jersey Innovation Institute (NJII) was awarded a four-year $50M PTN cooperative agreement from CMS. NJII formed the Garden Practice Transformation Network (GPTN).

Maryland PTN

The Maryland Health Care Commission, MedChi, The Maryland State Medical Society, and the University of Maryland School of Medicine Department of Family and Community Medicine partnered with NJII in 2016 to complete the CMS defined practice transformation activities in Maryland. The GPTN offered the following assistance to Maryland practices:

- Customized coaching on quality improvement, patient and family engagement, linkages to Maryland's State-Designated health information exchange, the Chesapeake Regional Information System for our Patients (CRISP);
- Leveraging meaningful use;
- Identifying and incorporating patient centered medical home model concepts into practice workflows;
- Support for physician quality reporting and interpreting results;
- Measuring outcomes for value-based payments under MACRA;
- Preparing for APMs;
- Navigating reporting programs for CMS compliance under MACRA; and,
- Performing data analysis for quality workflows and revenue improvement.

Program Participation



Key Program Elements

Patient and Family Engagement (PFE)

Engaging patients and their families requires proactive communication and opportunities for shared decision-making.[3] The aim of PFE is to improve care quality, reduce errors, and empower patients to manage and control their own health conditions.[4] The GPTN supported practices' patient and family engagement activities by creating statewide patient learning networks, holding education sessions, and developing engagement materials. Practices reported PFE measures to track progress towards incorporating PFE into care delivery.

PFE Measures:

Support for Patient and Family Voices – Policies, procedures and actions taken to support patient and family participation in practice decision-making (e.g., patient and family advisory councils, practice improvement teams, board representatives, etc.).

Shared Decision-Making – Supporting shared decision-making by training and ensuring that clinical teams integrate patient-identified goals, preferences, concerns and desired outcomes into the treatment plan (e.g., those based on the individual's culture, language, spiritual views, social determinants of health, etc.).

Patient Activation – Using a tool to assess and measure patient activation such as the Patient Activation Measure or other tools that measure patients' willingness and capacity to take on the role of managing their own health and health care.

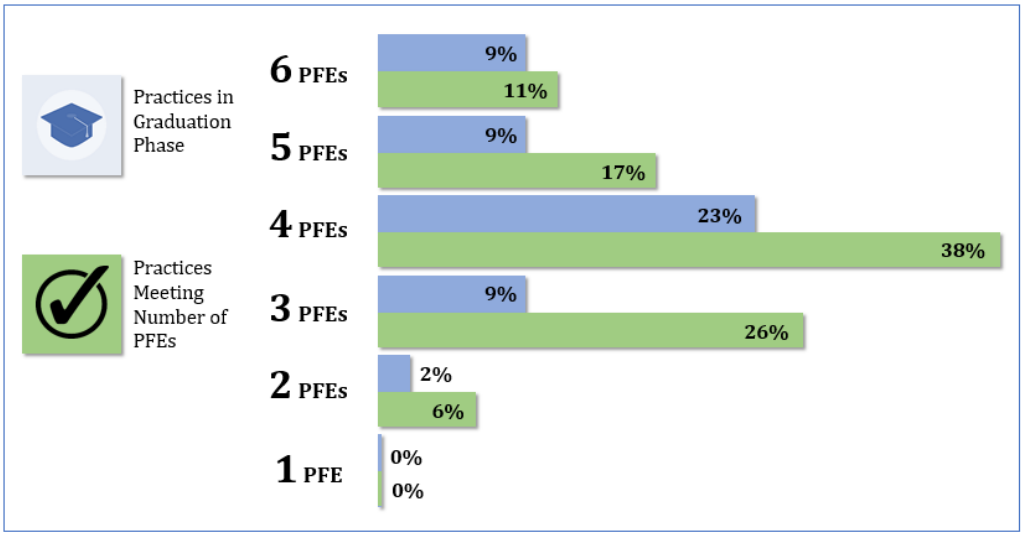
Active e-Tool – Use of a patient portal or other technology accessible to both patients and clinicians to share information such as test results, medication list, vitals, and patient health record data.

Health Literacy Survey - Using a health literacy patient survey (e.g., Consumer Assessment of Healthcare Providers & Systems (CAHPS) Health Literacy Item Set)

Medication Management - Clinical team works with the patients and families to support medication management.

*PFE measures are grouped into three categories: Point of Care, Policies and Procedures, and Governance.[5]

Figure 1. PFE Measure Performance



Quality Measures

Performance measurement is a central component of value-based care delivery and advanced payment models.[6] PTNs joining the TCPI were required to have a measurement strategy in place and a proposed measurement set tailored to the needs of their practices.[7] Practices participating in the GPTN reported National Quality Forum (NQF) measures[8] for the purpose of monitoring progress on performance improvement and model evaluation.

National Quality Forum (NQF) Measures Reported

- *NQF 0326: Care Plan* – Percentage of patients aged 65 years and older with an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical

record that an advance care plan was discussed, and the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.

- *NQF 0034: Colorectal Cancer Screening* – Percentage of patients 50–75 years of age who had appropriate screening for colorectal cancer.
- *NQF 0018: Controlling High Blood Pressure* – Percentage of patients 18 to 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year.
- *NQF 0059: Diabetes, Hemoglobin A1c (HbA1c) Poor Control* – Percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year was greater than 9.0 percent (poor control) or was missing a result, or if an HbA1c test was not done during the measurement year.
- *NQF 0062: Diabetes, Medical Attention to Nephropathy* – Percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who received a nephropathy screening test or monitoring test or had evidence of nephropathy during the measurement year.
- *NQF 0028: Tobacco Use, Screening and Cessation Intervention* – Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months and who received cessation intervention if identified as a tobacco user.

Figure 2. Number of Quality Measures Improved Upon by Participating Practices

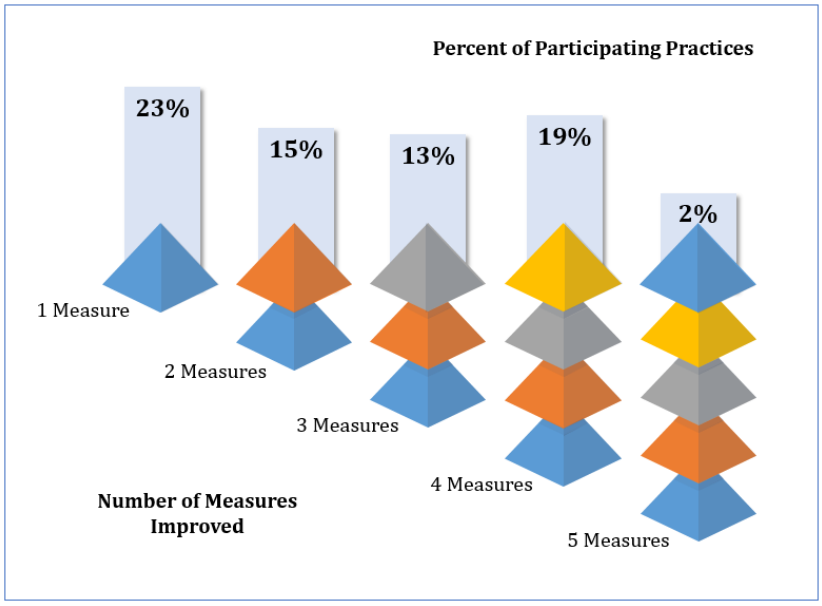
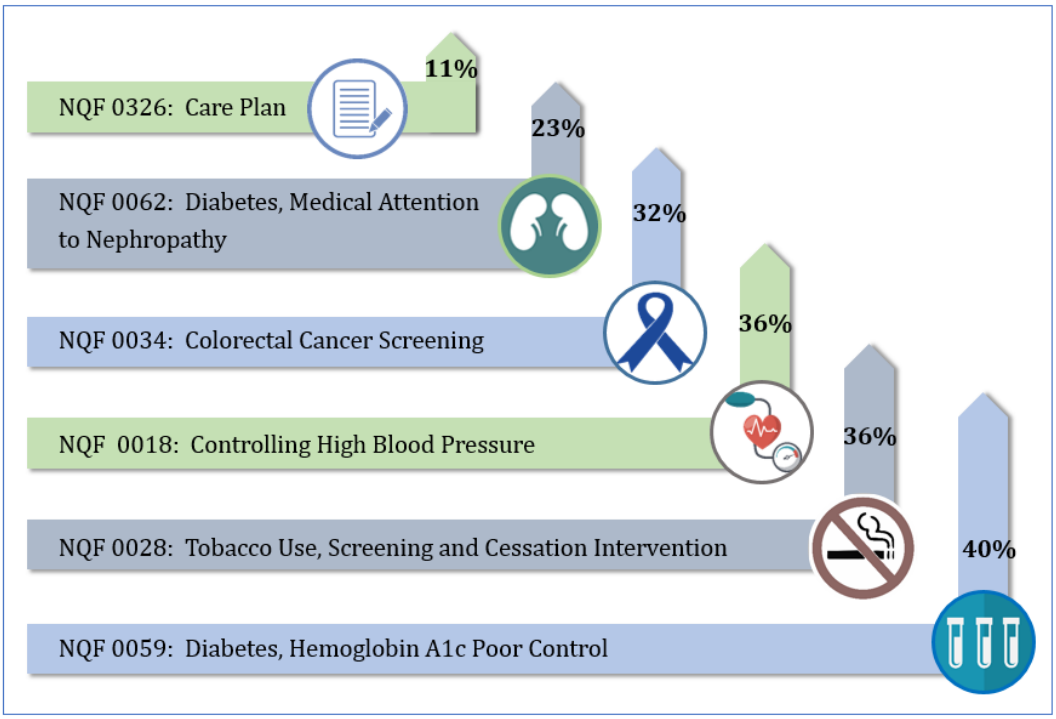


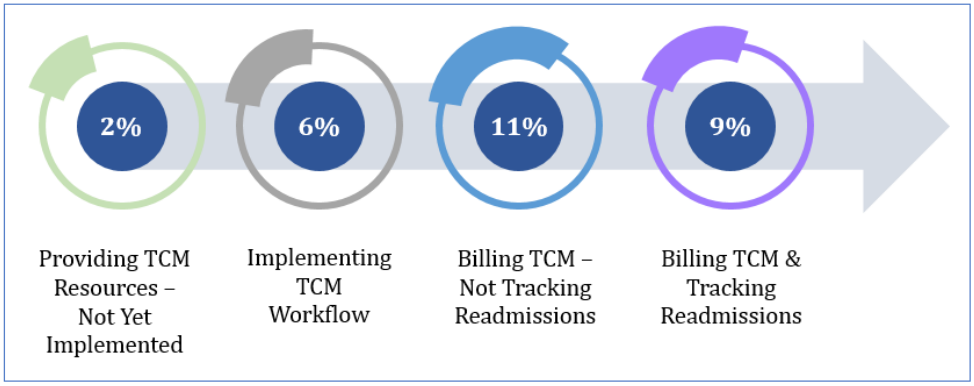
Figure 3. Rate of Improvement on Quality Measures



Transitional Care Management (TCM)

TCM services provide coordinated care following discharge from a hospital or other health care facility to improve care and help prevent unnecessary readmissions.[9] GPTN coaches provided information to participating practices on planning for and facilitating transitions across care settings.[10] Many current value-based care programs in Maryland measure TCM, including the Maryland Primary Care Program (MDPCP)[11].

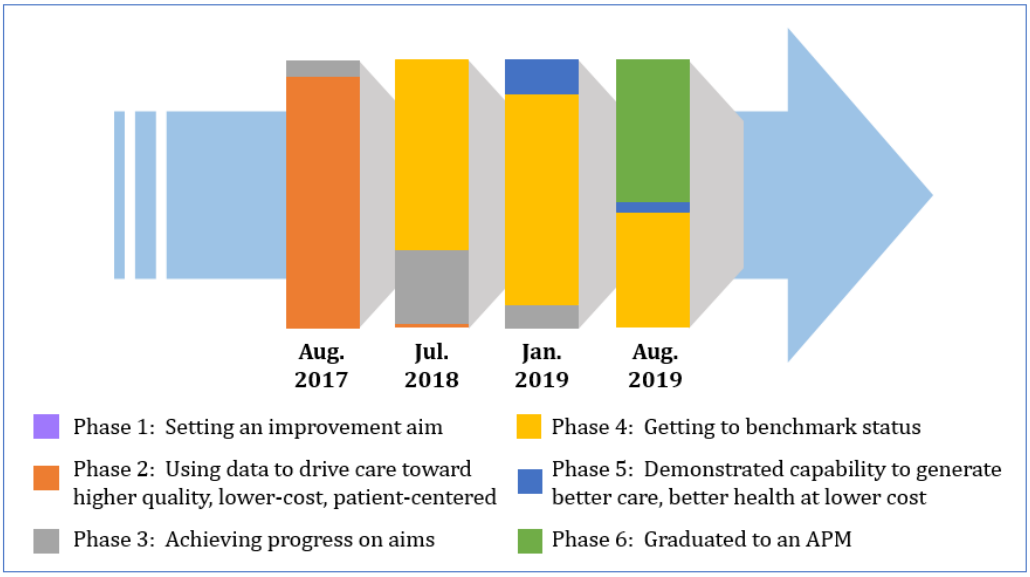
Figure 4. Practices Providing TCM Support



Phased Transformation

Practices' transition towards readiness to participate in APMs occurred in six phases.[12] Coaching and technical assistance supported practice development of core competencies related to the overarching goals of TCPI.[13]

Figure 5. Practice Progress through Program Phases[14, 15]



Program Results

As of May 2019, practices participating in the TCPI nationally showed progress on five of seven program aims:

- Supported more than 124,000 clinicians in transformation work;
- Improved health outcomes for more than 9 million beneficiaries;
- Reduced unnecessary hospitalizations for 5 million (@116.2/1,000 = 581,000);
- Generated more than $4 billion in savings to payers; and
- Reduced unnecessary tests and procedures by over 334,000.

Additional national aims included transitioning 75 percent of practices to APMs and building the evidence base so effective solutions can be scaled. Maryland practices advanced from 94 percent being at Phase 2 at the onset of the program, to 51 percent graduating (or being near ready to graduate) to an APM.

Conclusion

Practice transformation improves quality performance, efficiency, connectivity, patient-centered care delivery, and care coordination.[16] Practices performing at or above benchmark were considered by CMMI to be strong evidence of transformation. Nearly all (98 percent) of Maryland practices engaged in the GPTN

achieved benchmark status or above. GPTN efforts for engaged practices in Maryland were successful in achieving practice transformation as defined by CMMI for this initiative.

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[1] Centers for Medicare & Medicaid Services (CMS), Transforming Clinical Practice Initiative. Available at: innovation.cms.gov/innovation-models/transforming-clinical-practices.
[2] Practice transformation is a process of change to advance quality improvement and patient-centered care health care delivery.
[3] CMS, Person and Family Engagement (PFE) Toolkit, April 2020. Available at: www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Downloads/Person-and-Family-Engagemen.pdf.
[4] Cené CW, Johnson BH, Turchi R, A Narrative Review of Patient and Family Engagement: The "Foundation" of the Medical Home, *Medical Care* (2016). Available at: www.ncbi.nlm.nih.gov/pmc/articles/PMC4907812/#!po=26.0000.
[5] Primary Care Collaborative, Improving Your Person and Family Engagement Metrics in TCPI. Available at: www.pcpcc.org/tcpi/improving-metrics.
[6] Health Affairs, Getting To The Next Generation Of Performance Measures For Value-Based Payment, January 2019. Available at: www.healthaffairs.org/do/10.1377/hblog20190128.477681/full/.
[7] CMS, Transforming Clinical Practice Initiatives (TCPI) Practice Transformation Networks (PTNs) Funding Opportunity Announcement, October 2014. Available at: innovation.cms.gov/files/x/tcpi-foa-ptn.pdf.
[8] National Quality Forum (NQF) performance measures are evaluated, endorsed, and often align across national programs. More information on NQF measures can be found at: www.qualityforum.org/Home.aspx.
[9] American Academy of Family Physicians. Transitional Care Management. Available at: www.aafp.org/practice-management/payment/coding/medicare-coordination-services/tcm.html#:~:text=Transitional%20Care%20Management%20(TCM)%20addresses,or%20change%20in%20medication%20therapy.
[10] See n. 7, *Supra*.
[11] The Maryland Primary Care Program (MDPCP) is a key initiative under Maryland's Total Cost of Care All-Payer Model (TCOC). The MDPCP integrates care management into primary care and specialty provider practices to advance primary care throughout the State. More information is available at: health.maryland.gov/mdpcp/Pages/home.aspx.
[12] CMS, Transforming Clinical Practice Initiative Support and Alignment Networks 2.0, September 2016. Available at: www.cms.gov/newsroom/fact-sheets/transforming-clinical-practice-initiative-support-and-alignment-networks-20-0.
[13] CMS, Transforming Clinical Practice Initiatives (TCPI) Practice Transformation Networks (PTNs) Funding Opportunity Announcement, October 2014. Available at: innovation.cms.gov/files/x/tcpi-foa-ptn.pdf.
[14] Results from August 2017 through January 2019 were reported by the GPTN in January 2019.
[15] More information on TCPI phases is available at: innovation.cms.gov/files/x/tcpi-foa-ptn.pdf.
[16] Khanna N, Gritzer L, Klyushnenkova E, et.al., Practice Transformation Analytics Dashboard for Clinician Engagement, *The Annals of Family Medicine,* August 2019. Available at: www.annfammed.org/content/17/Suppl_1/S73.long.