MARYLAND
Health Care
Commission

Innovative Care Delivery Models:

Implementing Continuous Quality Improvement

DECEMBER 13, 2024

CME Disclosure, Accreditation and Designation Statement

- **Accreditation Statement**

  This activity has been planned and implemented in accordance with the Essential Areas and policies of the Accreditation Council for Continuing Medical Education through the joint providership of MedChi, The Maryland State Medical Society and The Maryland Health Care Commission. MedChi is accredited by the ACCME to provide continuing medical education for physicians.

- **Designation Statement**

  MedChi designates this virtual meeting for a maximum of 1AMA PRA Category 1 Credits. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

- **Disclosure Statement**

  The planners and reviewers for this activity have reported no relevant financial relationships to disclose.

Learning Objectives

- Recognize areas where patient care can be improved through data analysis and feedback
- Set goals with clear and measurable targets for improvement
- Implement changes by testing new approaches and interventions to address identified issues
- Regularly track progress and adjust as needed to optimize outcomes

AGENDA

I. **Melanie Cavaliere**, *MHCC*, Overview of Maryland Landscape and MHCC Practice Transformation Activities

II. Molly Daughtry, *Vice President, MedStar CTO*, Subject Matter Expert

III. Joseph Brodine, MD, *Franklin Square Family Health Center*, practice perspective

IV. Kashif Firozvi, MD, *Adventist Medical Group*, practice perspective

V. Q&A

Advancing Practice Transformation

Background

- Advancing practice transformation has been an MHCC strategic priority for more than a decade
- Maryland law tasked MHCC with implementation and management of the Maryland Multi-Payor PCMH Program from 2011 through 2016
- The MHCC, MedChi, and the University of Maryland School of Medicine Department of Family and Community Medicine partnered with the New Jersey Innovation Institute to complete practice transformation activities in Maryland as part of the federal Transforming Clinical Practice Initiative from 2015 to 2019
- The MHCC has contributed to planning and policy development for the Maryland Primary Care Program since its inception in 2017

Advancing Practice Transformation Program Overview

- In June 2021, MedChi CTO was competitively awarded a grant to complete transformation activities
- A crucial role of MedChi CTO is providing practice coaching on specific transformation topics and approaches, such as quality improvement and tools to help sequence and manage change essential to succeed in a value-based care model
- Program milestones:
  - Milestone 1 – Readiness Assessment
  - Milestone 2 – Workflow Redesign
  - Milestone 3 – Training
- Approximately 77 practices have completed program milestones to date

Learning Network Events

- The MHCC convenes peer learning network events in collaboration with local and national health care leaders on topics such as health equity, advanced care delivery, and practice transformation
- More information on learning network events is available at: mhcc.maryland.gov/mhcc/Pages/apc/apc_icd/apc_icd_learning_networks.aspx

Advanced Care Delivery Events

- Prior events available on the **Learning Network** include:

MENTAL HEALTH COLLABORATIVE CARE SUMMIT: NAVIGATING KEY TASKS AND ROLES

June 2024

Representatives from three physician practices and a subject matter expert discuss key considerations for implementing mental health collaborative care models, including treatment approaches and tips for defining the roles of primary care providers and behavioral health specialists.

Watch Now | Download Slides

EXPLORING CRISP DATA: BEST PRACTICES FOR ACCESS AND USE

October 2024

Representatives from three physician practices and a subject matter expert discuss the value and clinical benefit of utilizing data from CRISP, the State-Designated Health Information Exchange (HIE). Speakers explore ways HIEs can be leveraged to improve care delivery and chronic care management, such as incorporating HIE reports (e.g., radiology and laboratory reports) into practice workflows.

Watch Now | Download Slides

Launching in 2025

Molly Daughtry,

Vice President,
MedStar CTO,

Subject Matter Expert

Joseph Brodine, MD,

Franklin Square Family Health Center

Practice Perspective

MedStar Health

It's how we treat people.

Continuous Quality Improvement

Molly Daughtry, VP MedStar Care Transformation Organization
Dr. Joseph Brodine, Medical Director and Family Physician MedStar Health

Continuous Quality Improvement

“Continuous Quality Improvement (CQI) is a progressive incremental improvement of processes, safety, and patient care. The goal of CQI may include improvement of operations, outcomes, systems processes, improved work environment, or regulatory compliance.”

“Projects should be targeted at specific, quantifiable patient care or operational outcomes. Projects should be designed in line with institutional interests, values, and key stakeholders.”

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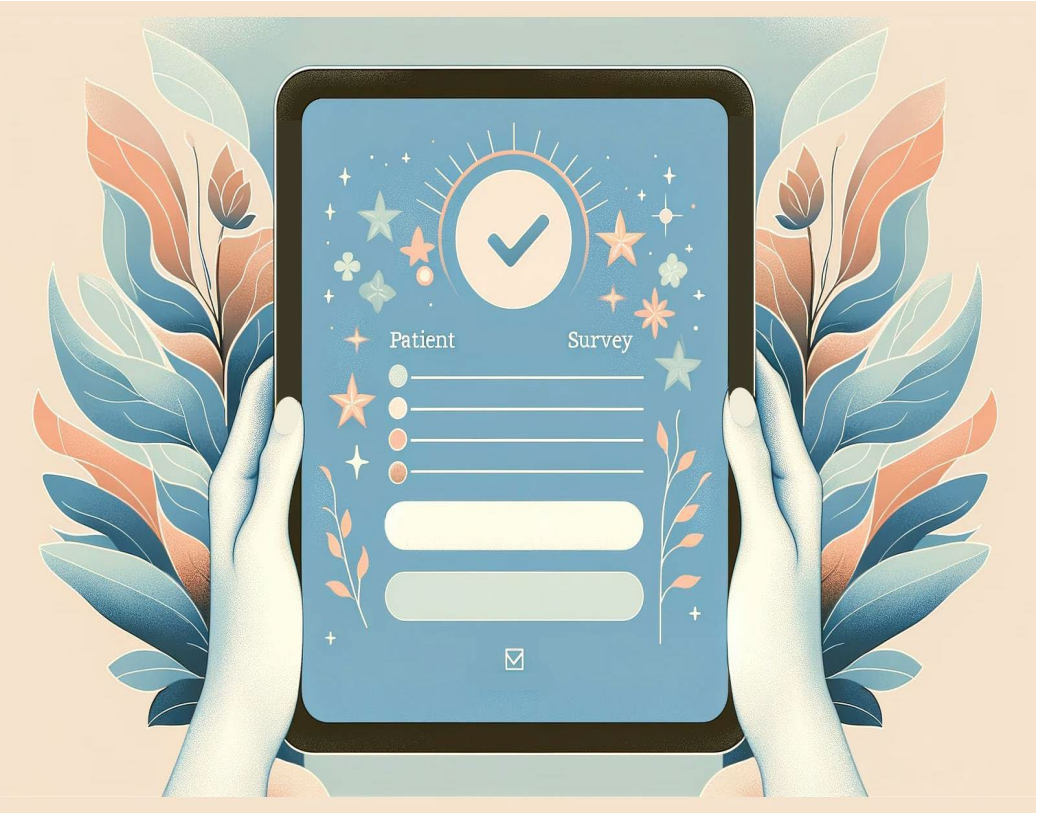
O'Donnell B, Gupta V. Continuous Quality Improvement. [Updated 2023 Apr 3]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2024 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK559239/

Identifying Improvement Needs

- Patient Feedback
  - Patient surveys
  - Patient and Family Advisory Council meetings
  - Comment boxes
  - Patient Portal messaging/requests



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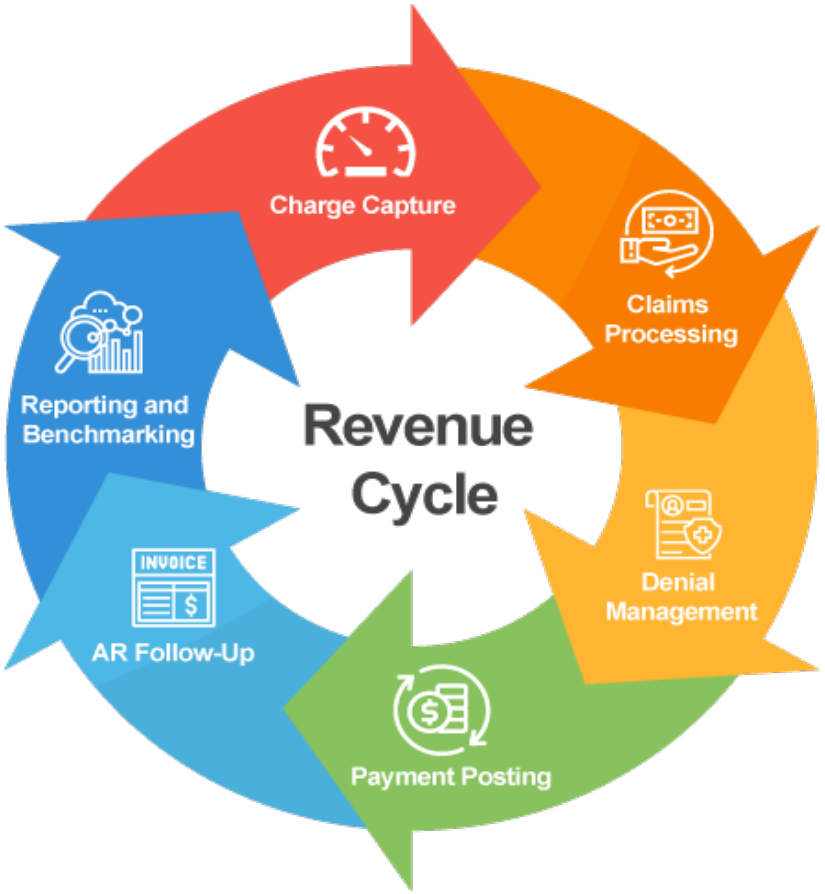
Identifying Improvement Needs

- Clinical Quality Data
- Appointment waiting room times
- Appointment data
  - Days to schedule-can be broken down by urgency
  - No-show rates
  - Cancellation and reschedule information

Identifying Improvement Needs



Revenue Cycle Management

- Patient Registration
- Medical Coding
- Patient Billing
- Administrative Denials

Clinical Denials

- Medical Necessity
- Authorizations

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Identifying Improvement Needs

- Value Based Contracts
  - Expectations specified by payor
- Centers for Medicaid and Medicare
  - Published benchmarks
- Managed Care Organizations
  - Published benchmarks

Prioritizing Improvement Needs

- Specific to your practice
- Clinical
- Financial
- Operational
- Programmatic

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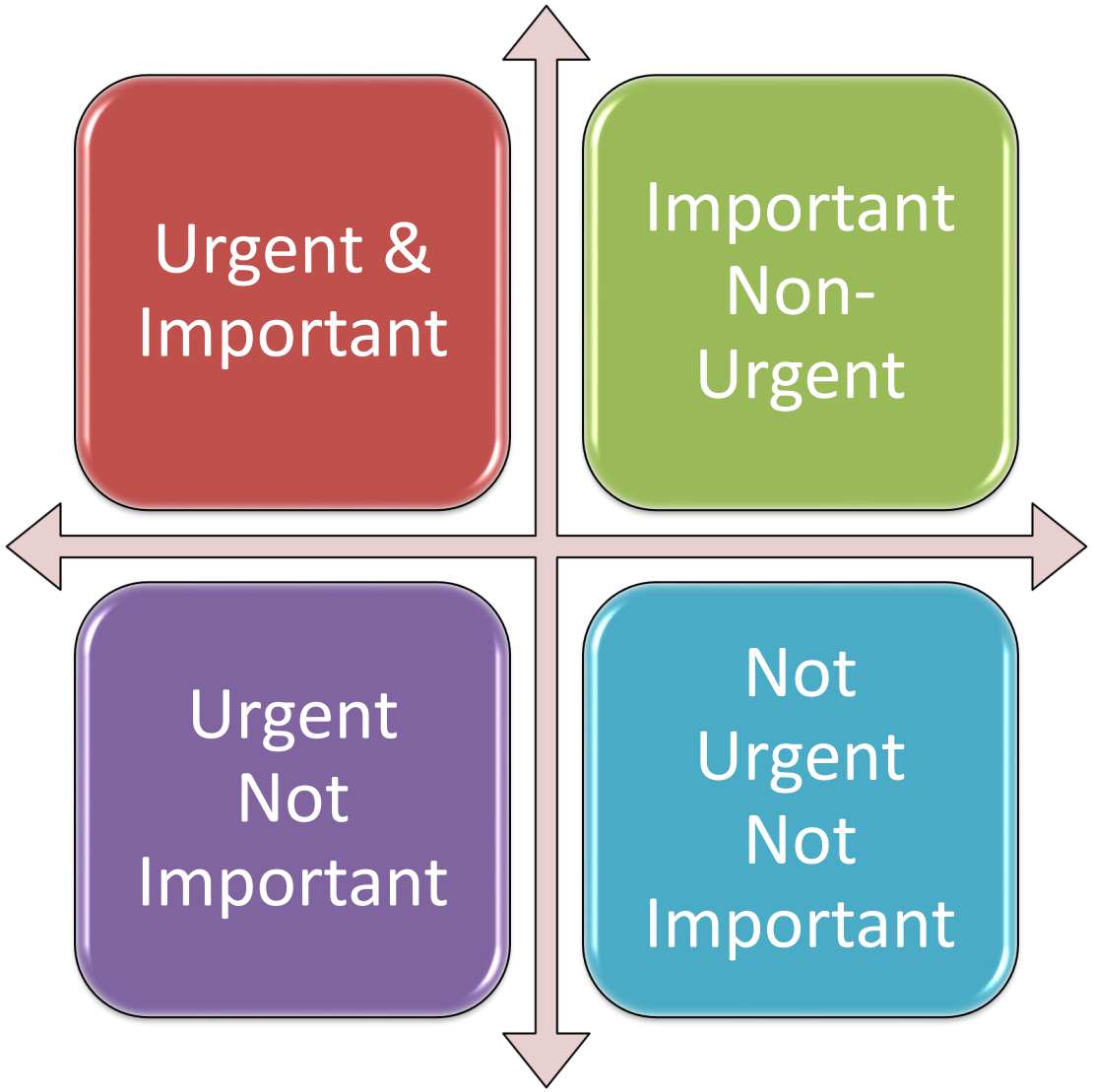
Prioritizing Improvement Needs



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Creating a Plan

- Start with the goal
  - What are you trying to achieve?
- Identify key stakeholders/subject matter experts (SME) for plan development
  - Dependent on chosen areas of improvement
- Commence initial meeting with stakeholders and SME
  - Lay out vision
- Establish metrics by which to measure progress

Create a Written Plan

Goal of Improvement Effort	Actions Required	Responsible Person	Resources Needed	Due Date	Status Updates	Comments

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Continuous Evaluation

- Establish regularly scheduled opportunities to evaluate progress and make adjustments
- Learn from each iteration findings and determine what changes need to take place moving forward
- Continue this cycle until project completion

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Real Life Example

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Background: the CTO and MDPCP

- The Care Transformation Organization (CTO) oversees MedStar's participation in the Maryland Primary Care Program
- Lives attributed to MedStar as of Q4 CY2023: 44,940
- MDPCP provides care management for Medicare B patients
  - A value-based care model
  - Incentives for good performance in cost and quality measures
  - Funding from the program supports efforts to address un-met care opportunities

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Controlling High Blood Pressure Control: a Challenging Measure

- The blood pressure challenge:
  - Good blood pressure control is clinically important
  - The CMS measure definition:
    - Whether a person with hypertension has a blood pressure <140 over <90
      - Determined by the LAST DOCUMENTED reading at the end of a calendar year!
  - So…a patient's many normal blood pressure readings can be "negated" by a single high reading at the end of the year!

Addressing HTN: Traditional Tactic

- CTO “Quality Team”
  - 5 MAs (including supervisor)
  - Directly call patients who are uncontrolled according to the measure
    - Documents patients’ self-reported blood pressure
- A “blood pressure sprint” at the end of the year
  - Aims to capture patients who are generally well controlled but whose most recent BP is elevated
  - Most patients who “failed” the measure were within about 10-15 mm Hg above the threshold

Automating Outreach:
A New Tactic for an Old Problem

- A new communication software platform called “Twistle” enables MedStar Health to communicate with patients through a dynamic, algorithmically driven text message exchange

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Methodology

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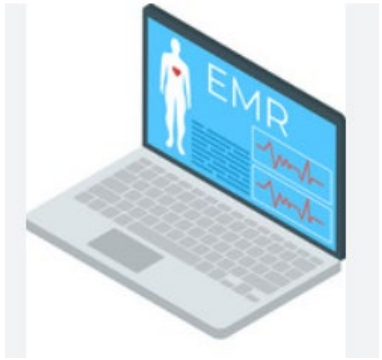
Meeting With Stakeholders

- Engaged with primary care leaders
  - Determined interest in the need
  - Developed a clinical approach to managing responses
- Partnered with digital health group at MedStar
  - Tested outreach process
- Organized Care Management team
  - Elicited input to inform development of workflow

Automated Outreach to Address HTN: Pilot Development

- Developed clinical and operational protocol
- Primary Aims:
  - Improve the accuracy of our measured performance
  - Efficiently identify patients with high-risk BP and respond clinically

Pilot Methodology



ORACLE

Patient's Blood Pressures upload from the EMR to the Analytics Engine

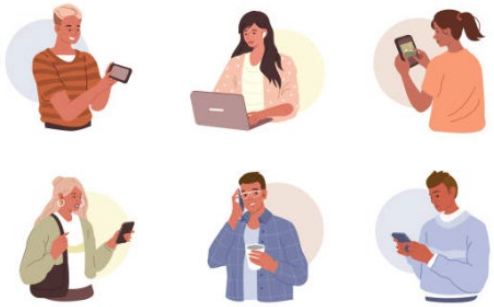
ANALYTICS CLOUD

ORACLE

A list of patients whose last BP was >140/>90 is loaded to Twistle

twistle
by HealthCatalyst

Patients receive a link to respond with their current blood pressure



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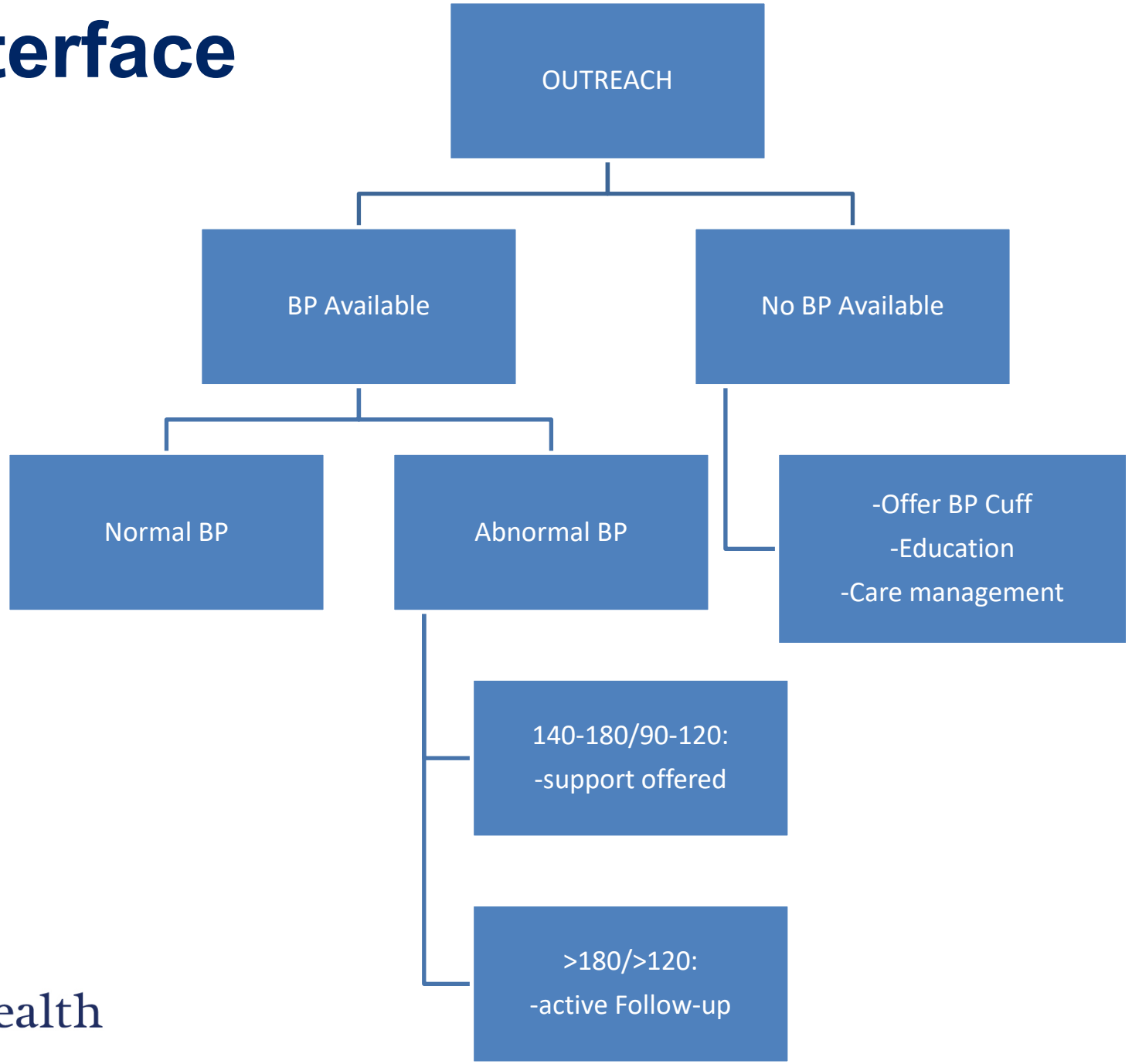
Chat Interface Logic



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CTO Blood Pressure Twistle Pathway Summary

SMS

You have a message from MedStar Health: please click on the link to see the message and reply. {Reply STOP to opt-out} https://twsl.co/g/TW2011XeE

Twistle

MedStar Health is reaching out to patients with hypertension (elevated blood pressure).

If you are no longer receiving your primary care at MedStar Health, please disregard this message.

MedStar Health
1m

Your care management team wants to check on your blood pressure and, if it is elevated, help you to get it under control.

Do you have a recent blood pressure taken since the last time that you saw your doctor? *

For example, a blood pressure reading from a home blood pressure cuff or collected at a non-MedStar location

- (•) Yes
- ( ) No

Please enter your blood pressure below, then click "Submit".

If you need information on how to take your blood pressure, please review the guide at https://tinyurl.com/54e5ya23

Thank you for replying to this message regarding your health.

Please be sure to discuss your blood pressure at your next visit with your primary care provider.

You may now CLOSE this window.

MedStar Health
now

MedStar Health

Implementation

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Preparation for Kick-Off

- Identified goal of reaching every PCP patient with last known BP out of range
  - ~11,000 patients
- Discussed current state of managing patient-reported blood pressures

Preparation for Kick-Off

- Consensus with leaders for blood pressure response
  - For normal blood pressure, upload into EMR and notify PCP
  - For elevated, non-emergency blood pressure, offer education, follow-up and notify PCP
  - For emergency blood pressure, immediate navigation for same-day clinical care

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Commencement of Outreach

- “Waves” of outreach of about 500 patients daily
- Daily check-in with Care Management team
  - Updated text-message language based on patient feedback
  - Identified resources to ensure timely clinical follow-up
- Weekly check-in with clinic leaders
  - Ensure that practices understand outreach process and are able to add patients with emergency-level BPs as needed

Results

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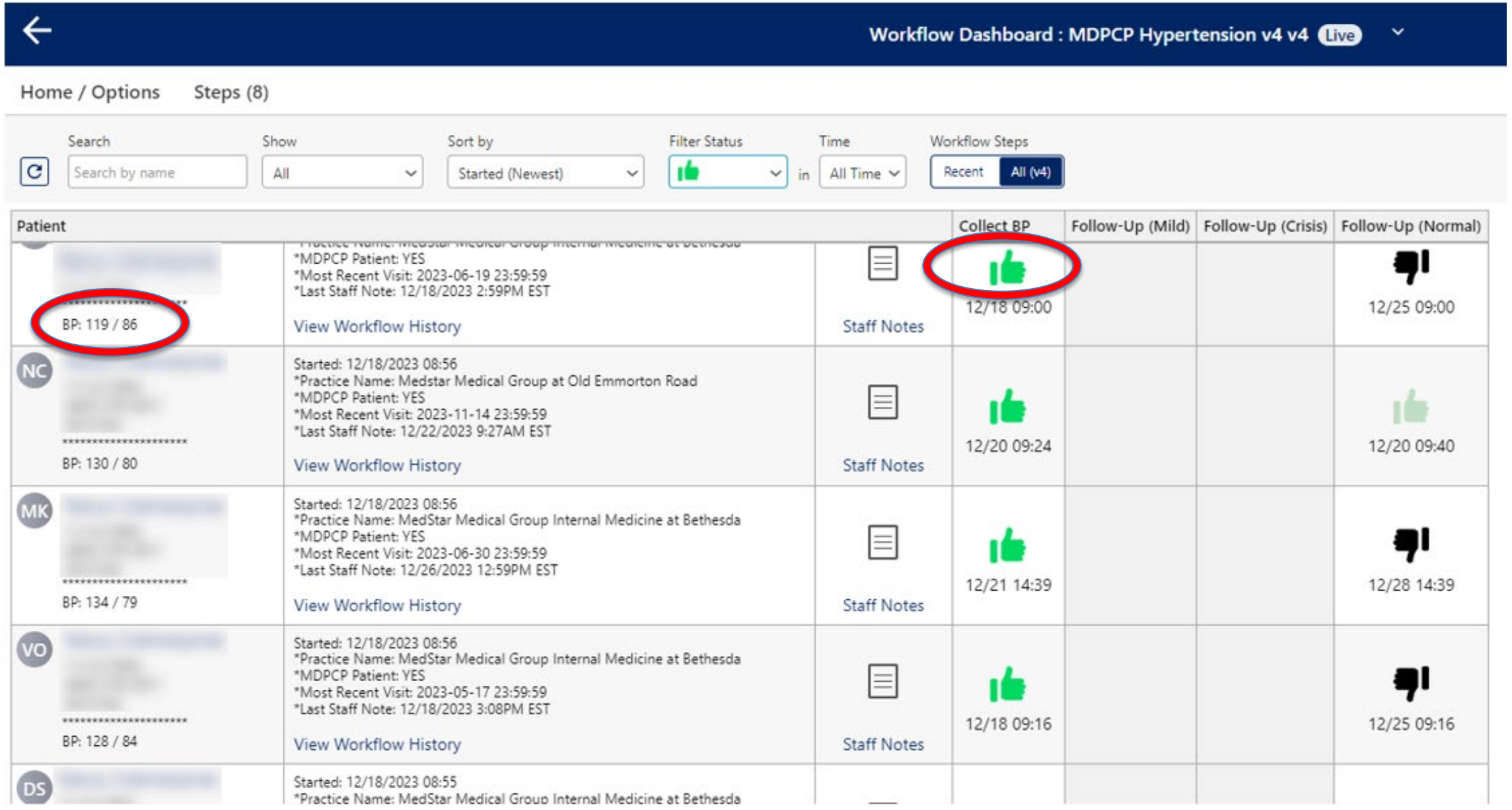
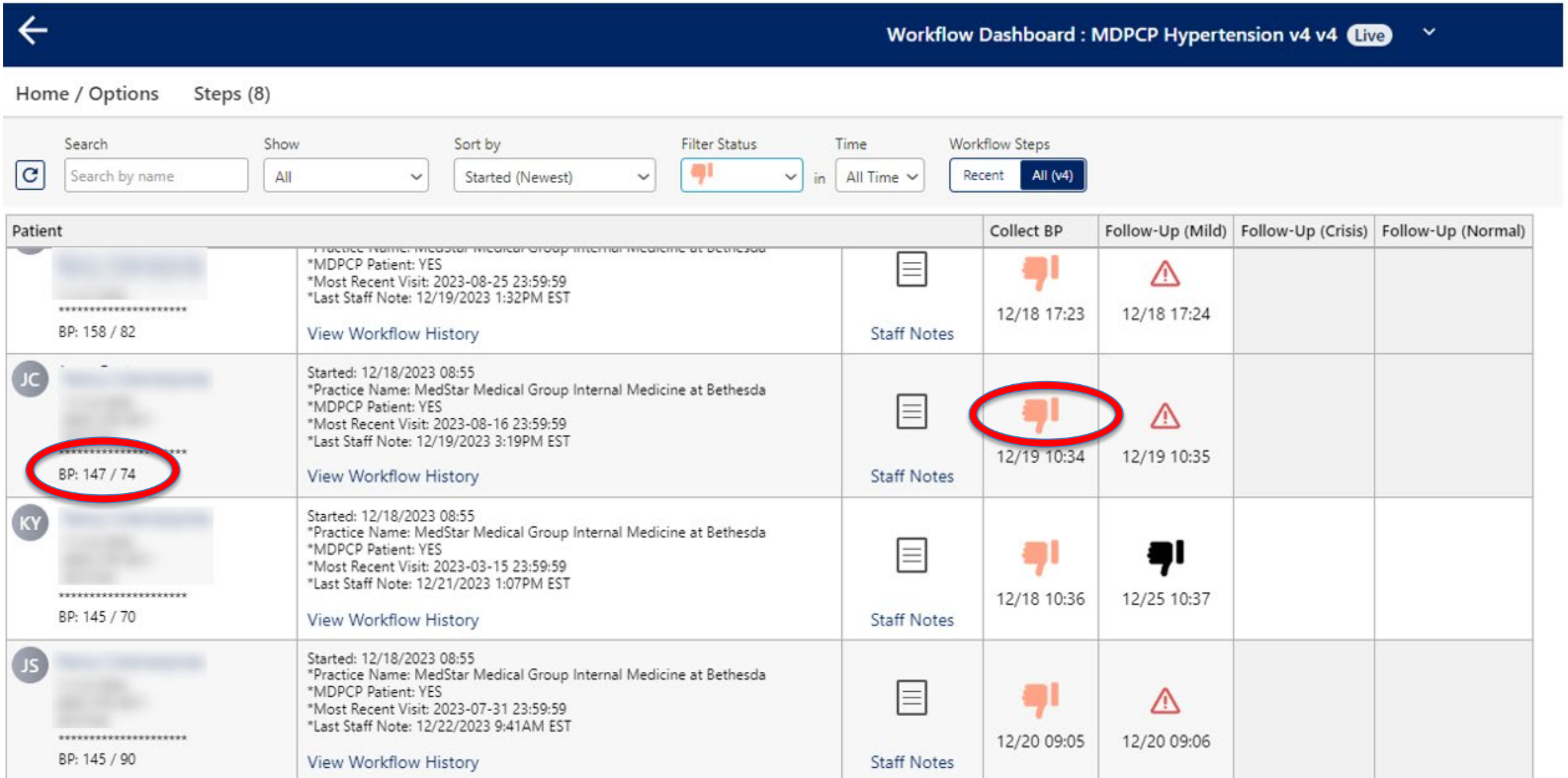
Pilot Deployment

- Deployed text message outreach
  - December 11-December 31
  - 10 “waves” of text messages (~500-2,000 pts per wave)
  - 9,216 patients received the link

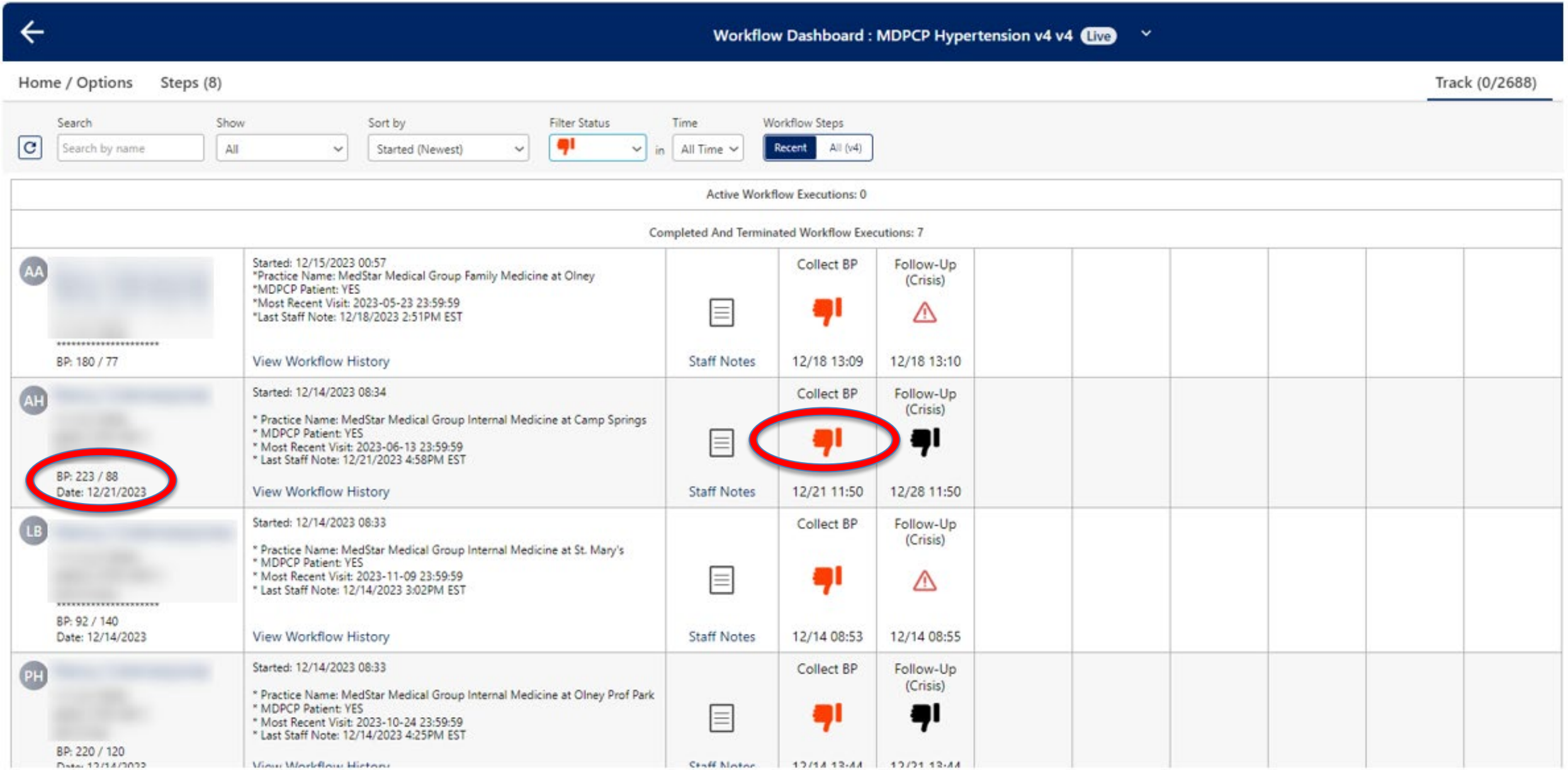
A look at the Twistle Dashboard…(normal)



A look at the Twistle Dashboard…(hypertensive)



A look at the Twistle Dashboard…(hypertensive crisis)

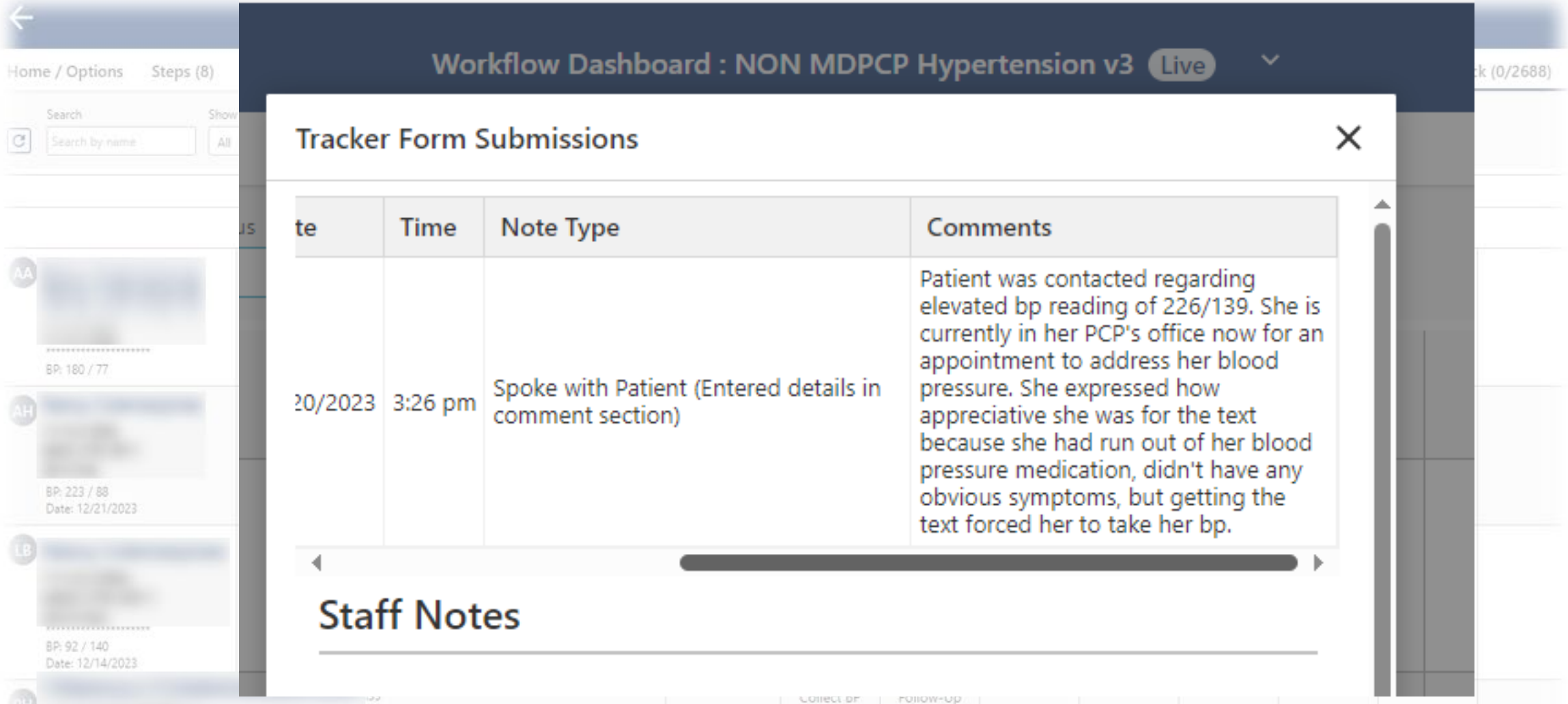


CTO Automated Blood Pressure Outreach Results (Dec 11-31, 2023)

BP Outreach Results		
Patients who Successfully Received a Link	9,216	100.0%
Patients who Clicked the Link	3,906	42.4%
Clicked Link but No Response	1,278	13.9%
Clicked Link and Submitted Responses	2,628	28.5%
Response Submitted	#	%
Normal blood pressure (<140/<90)	**787**	**8.5%**
Hypertensive (unchanged)	382	4.1%
Hypertensive Crisis (>180/>120)	40	0.4%
Did not have recent home BP	1,419	15.0%

Hypertensive Crisis Patients:
- Every patient received immediate follow-up from CTO Team
- Patients scheduled for same day visit with their PCP or E-Visit or Urgent Care
- Prescriptions refilled

Safety Embedded in Quality Improvement



Automated Outreach: Take-Home

- Automated outreach is an effective way to communicate with patients
  - Serves as a “force multiplier” for existing teams performing manual outreach
  - Improves quality measures AND quality of care
  - Offers insights for workflow improvements

Automated Outreach: Next Steps

- Combine with analysis of other projects to determine impact on populations with regard to health and equity
- Iteratively improve on pathway for HTN
  - Connect patients with virtual services to accelerate follow-up
- Explore other opportunities to apply to care management activities
  - E.g., remote management of blood pressure

Thank you

It's how we treat people.

Kashif Firozvi, MD,

Medical Oncology
Hematology

practice perspective

Agenda

- Objectives
- Introduction to Physician Alliance CIN
- Problem & Goal
- Methodology
- Implementation
- Results
- Real Life Examples
- Looking Ahead

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Objectives

1. Understand benefits of In-network Care
2. Understand AHC in-network care methodology
3. Identify areas of collaborative innovation
4. Understand in-network care real life examples

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Adventist HealthCare Physician Alliance

Better Care, Better Results, Better Together

A **physician-led** Clinically Integrated Network of **2,300+** aligned and employed physicians in the Washington, D.C. region working collaboratively to:

- **Improve quality of care**
- **Lower healthcare costs**
- **Optimize patient experience**

500+ Primary Cares Providers	**115+** Total aligned practices
800+ Specialty Care Providers	**81,000+** Value-based patient lives
600+ Hospital-based Providers	**$5.6 Mil** In Value Based revenue for 2023

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In Network Care

Promoting Collaborative Innovation

Findings:

- The Physician Alliance is a high-quality, low-cost network*
- Has a robust specialty network of 30+ specialties/subspecialties
- 2,300+ providers are on separate EMRs & unaware of referral resources

Goal: Maintain network integrity to improve quality of care and lower cost for our patients/community.

**Analysis from CareFirst and CareJourney Data Sources*

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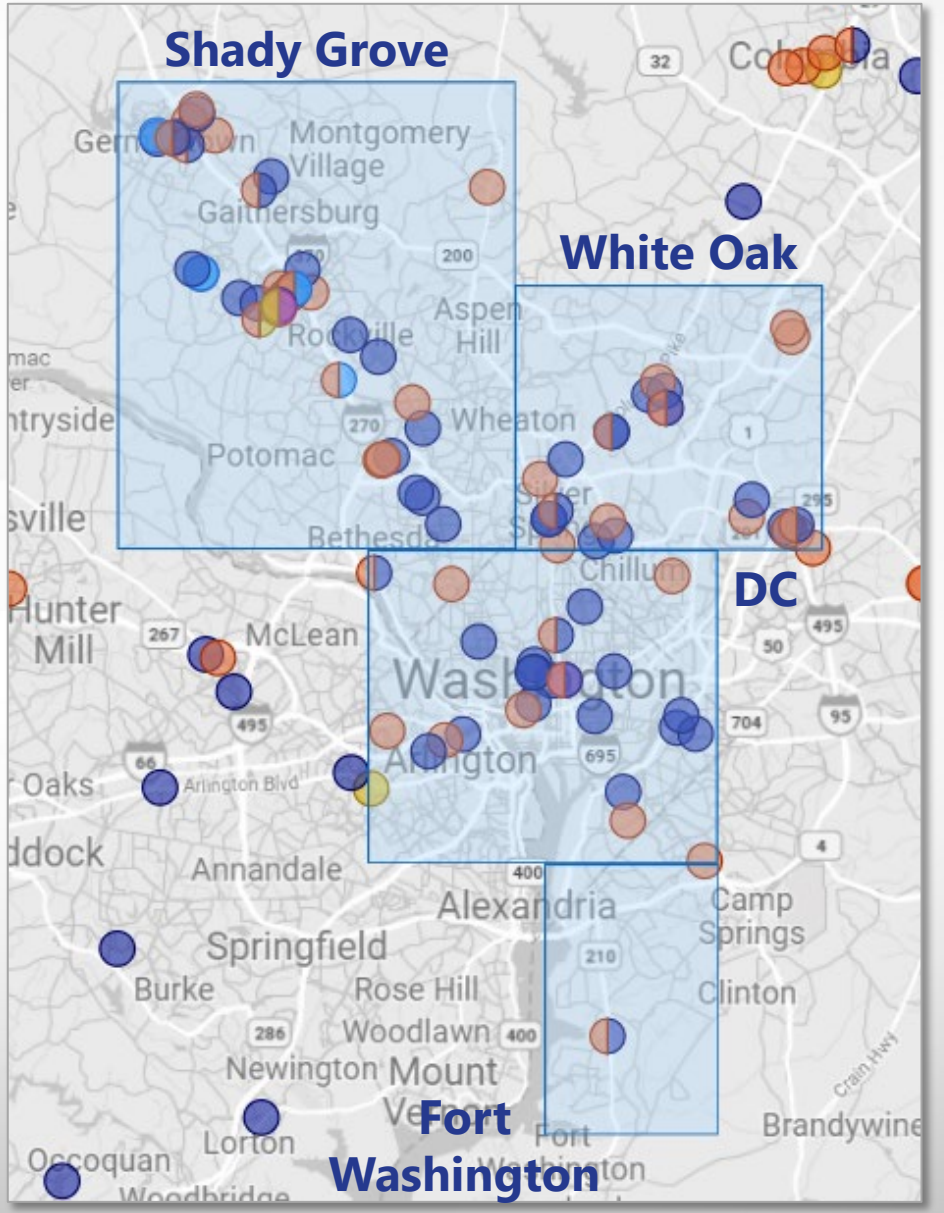
Physician Alliance Geography
Medical Neighborhoods



Process Methodology

Develop Committee

Developed committee comprised of PCPs and specialty providers to ensure work is physician-led

Data Analysis

- Reviewed current state referral data
- Invited experts to speak

Design Implementation

- Developed initiatives based on data analysis
- Implemented partnership with referral management and communication platform

Initiate Pilot

Piloted 3 specialty areas of focus with highest spend

- Cardiology
- Orthopedics
- Heme/Onc

Monitor & Expand Scope

Continually monitor progress with measures of success and review initiatives

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Implementing Collaborative Innovation

Build Trusting Relationships

Organized social events for primary care and specialty care providers to develop trusting relationships.

Improve Network Awareness

Built and disseminated full provider directories to improve network awareness.

Reduce Referral Friction & Improve Access to Care

Integrated a HIPAA compliant referral communication & management tool to allow for seamless care coordination.

Reduce Cost

Analyzed & disseminated CareFirst and CareJourney cost scorecards. Outlined areas to improve cost scores.

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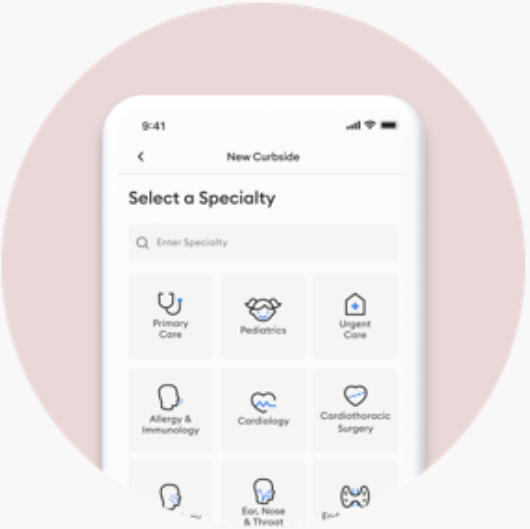
PicassoMD Referral Management Platform

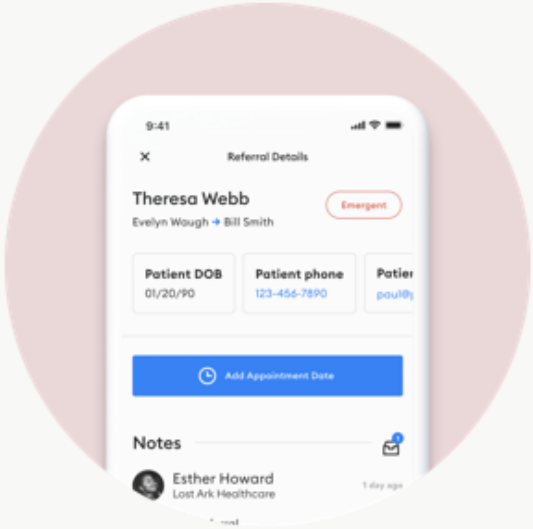
Step 1:
Remove Avoidable Referrals & ED visits



PicassoMD Curbsides

On-demand e-consults with specialists <2 min

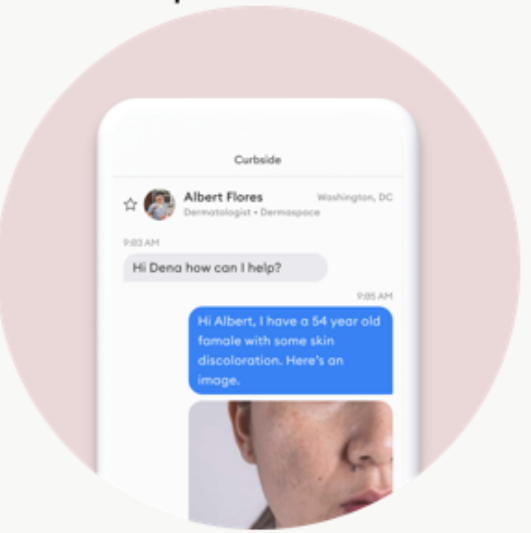
Step 2:
Add Directionality & Efficiency to Referrals



Rapid Referrals

Network Navigation, Seamlessly integrated referrals

Step 3:
Layer in Existing Resources to Improve Transitions & Close Gaps in Care



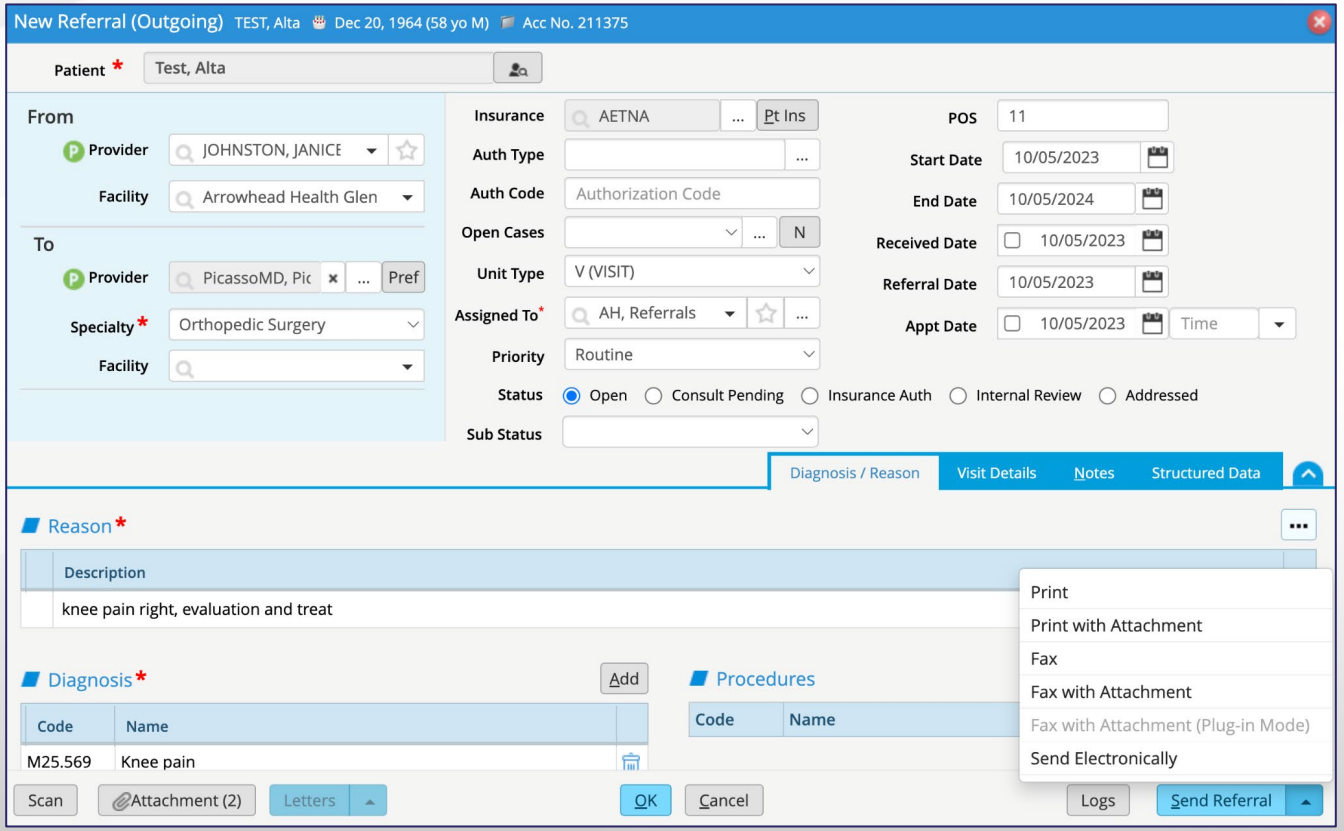
Care Coordination

HIPAA-secure channels for provider-to-provide, practice-to-practice, and payer-to-practice communication

PicassoMD Integration – Primary Care

Primary Cares send referrals directly through their EMR by selecting PicassoMD as the provider (eCW sample below).

On the back-end, Providers set up their favorite specialists. The PicassoMD algorithm then chooses a specialist based on patient location, cost, and insurance.



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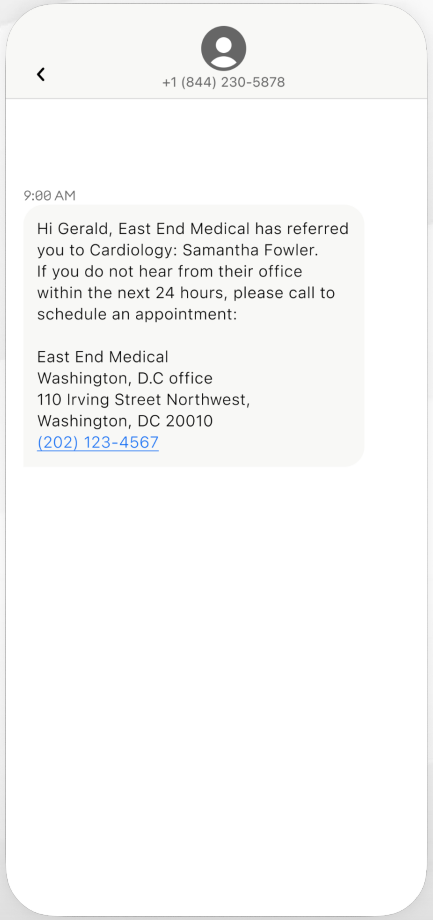
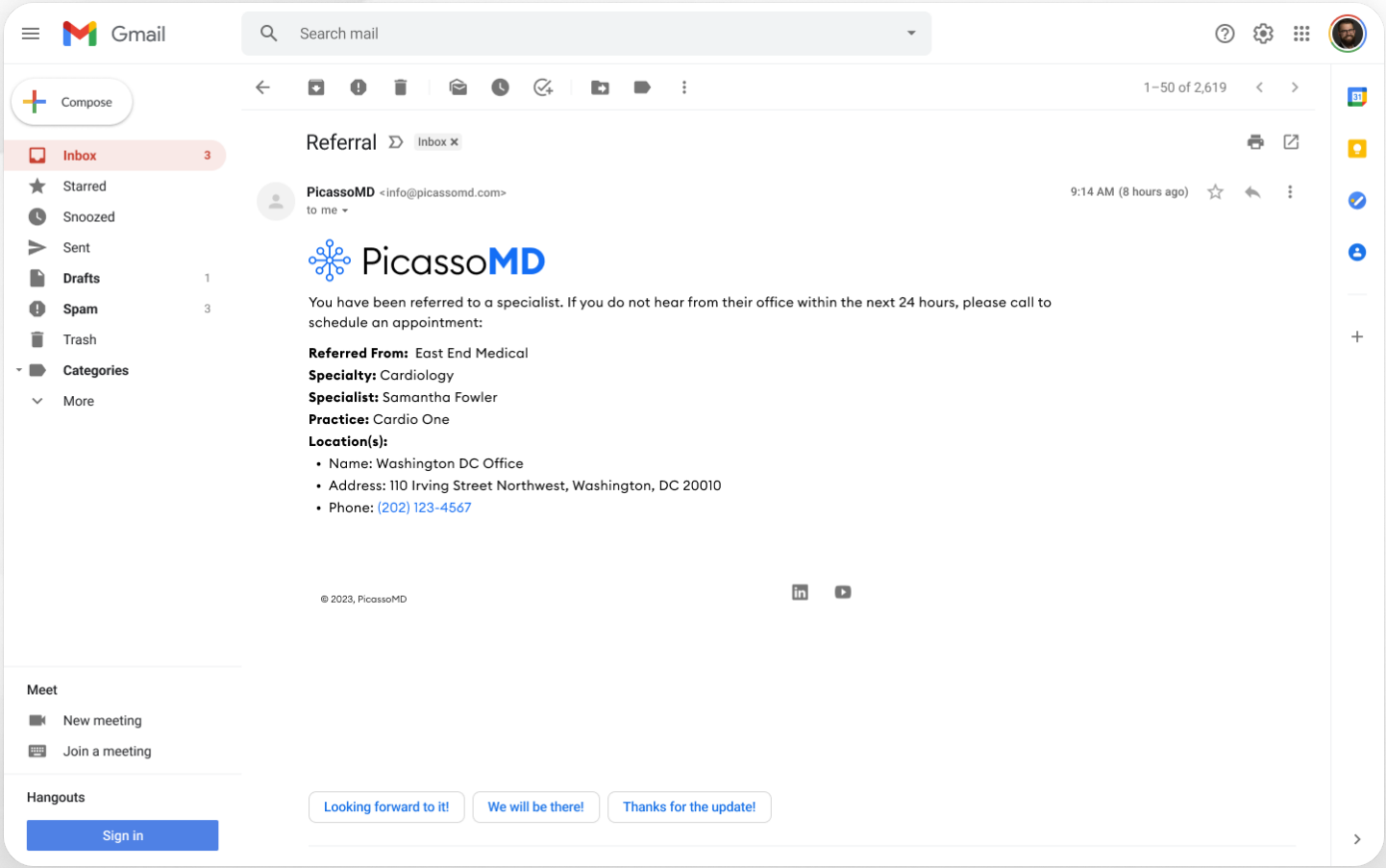
PicassoMD Integration – Patient

Patient notification via text



Patient notification via email



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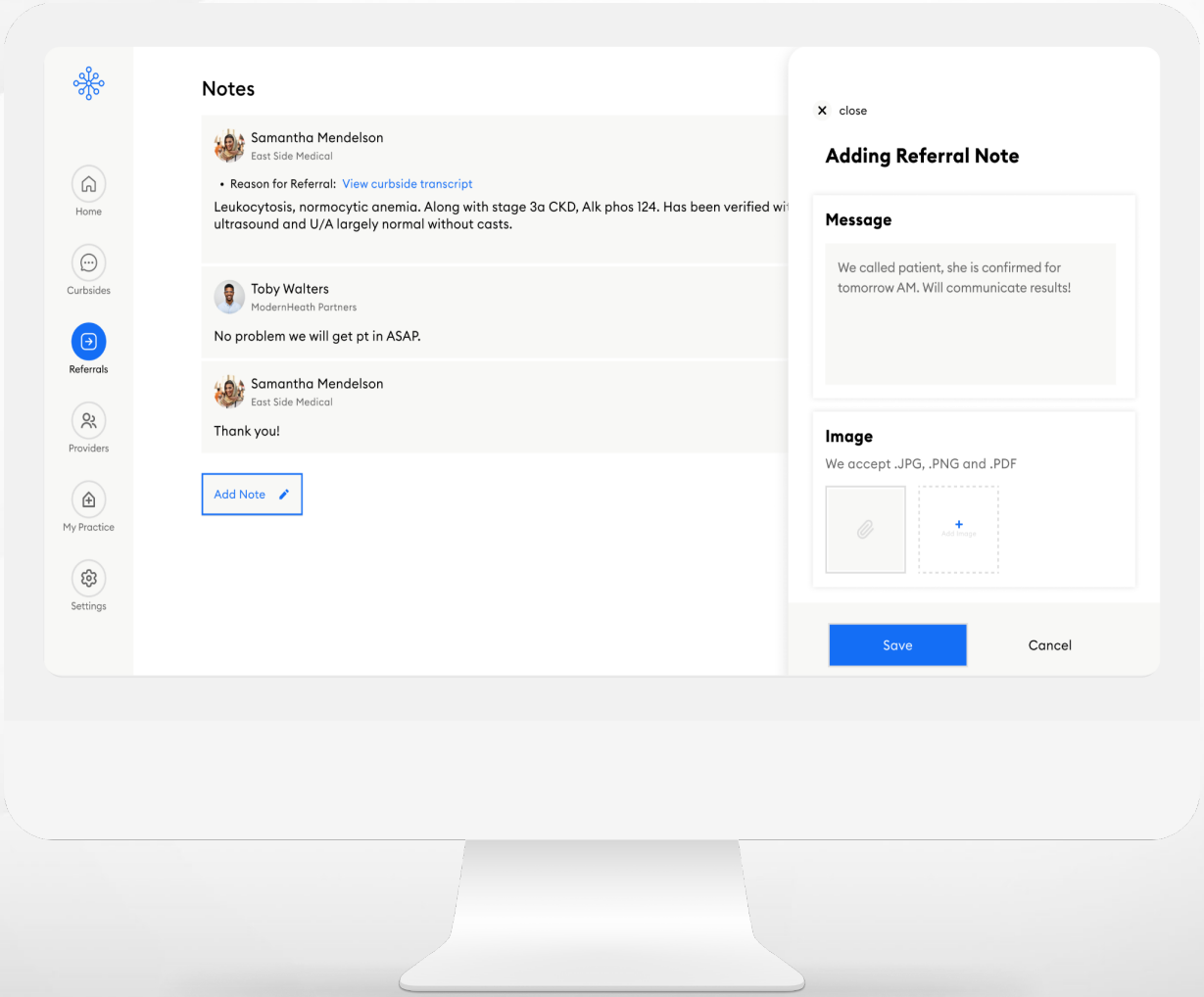
PicassoMD Integration – Specialty Practice

- Upon creating a referral, a HIPAA compliant channel is created enabling communication between the PCP and specialist. Providers can:
  - Send messages
  - Attach patient documents
  - Send office notes

- PCPs & Specialists can easily manage their referrals, communicate, and close the referral loop.



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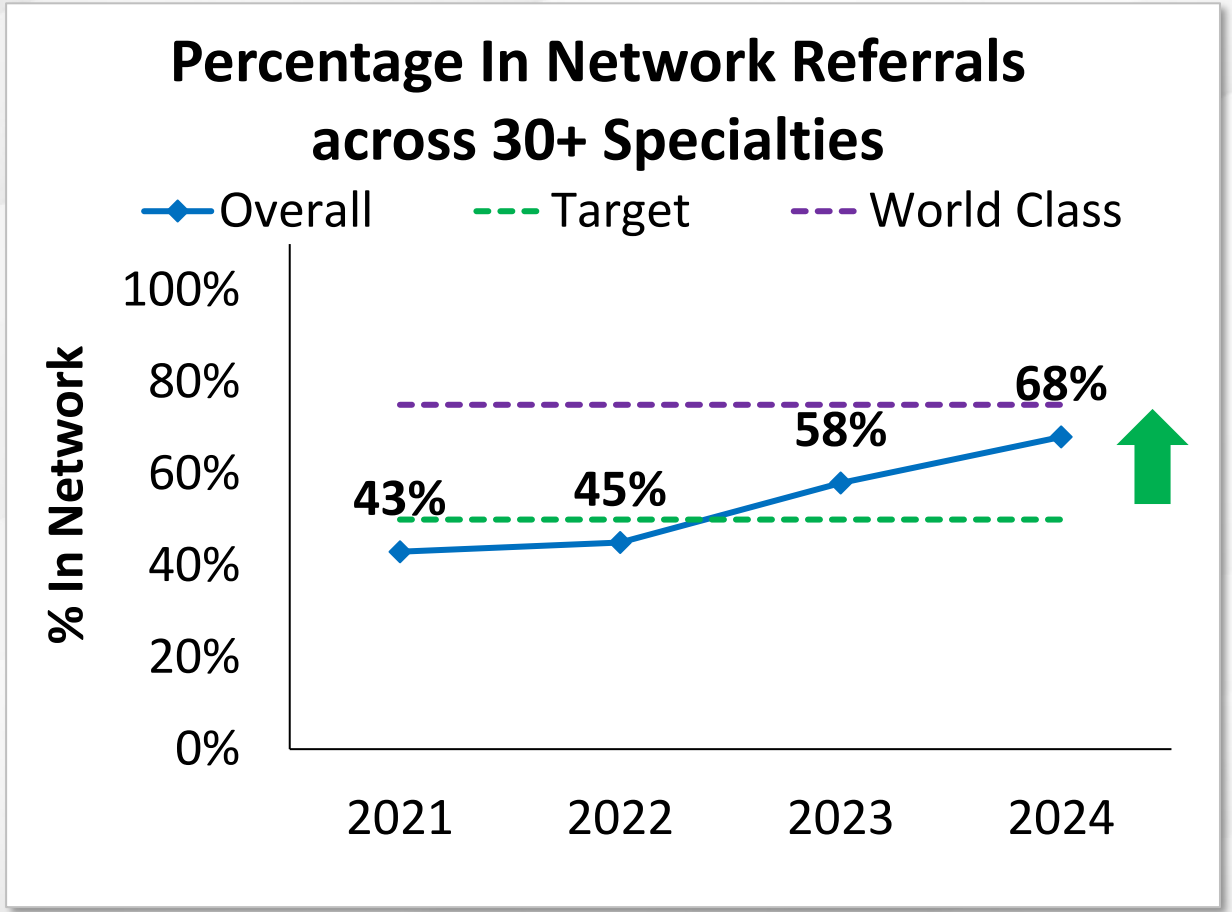
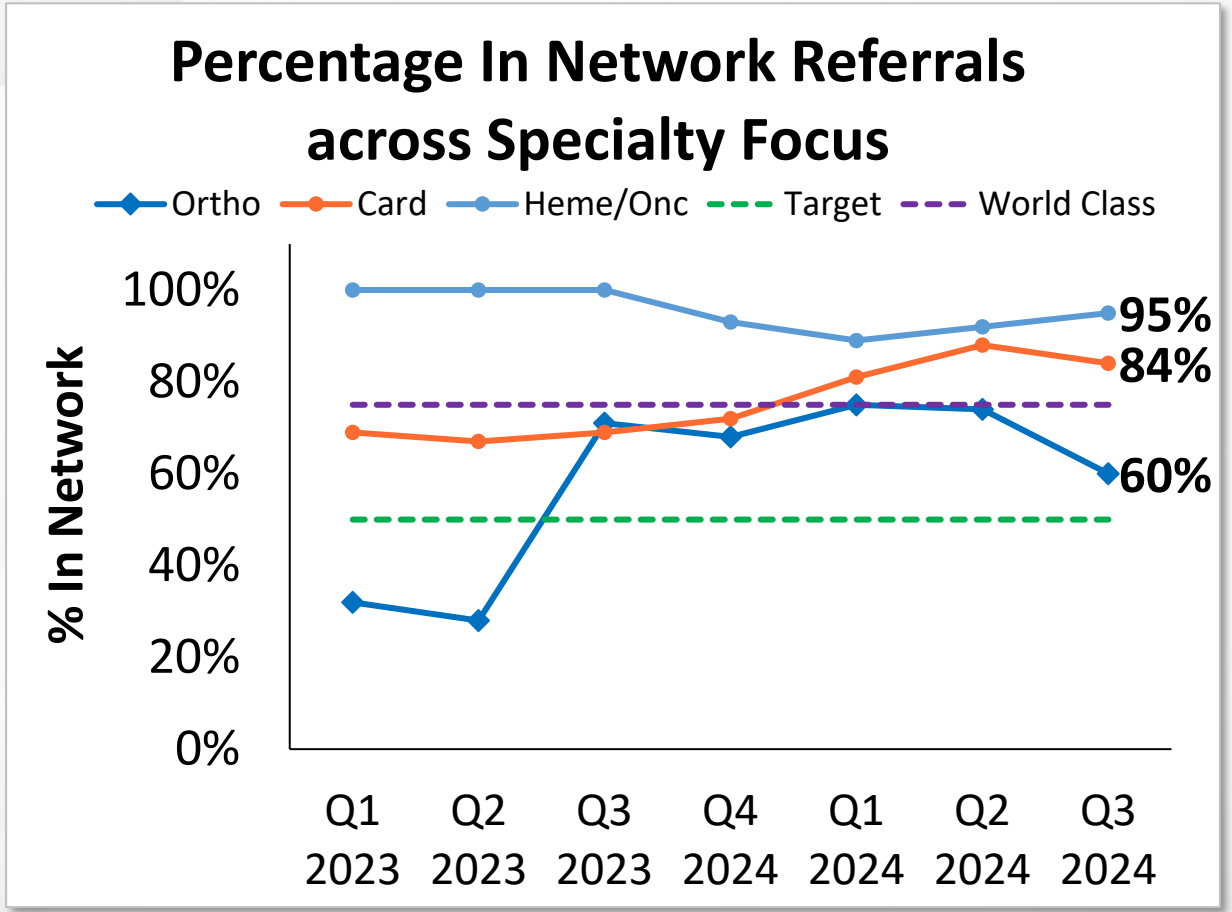
Our Measures of Success





13,000+Referrals sent through the PicassoMD integration

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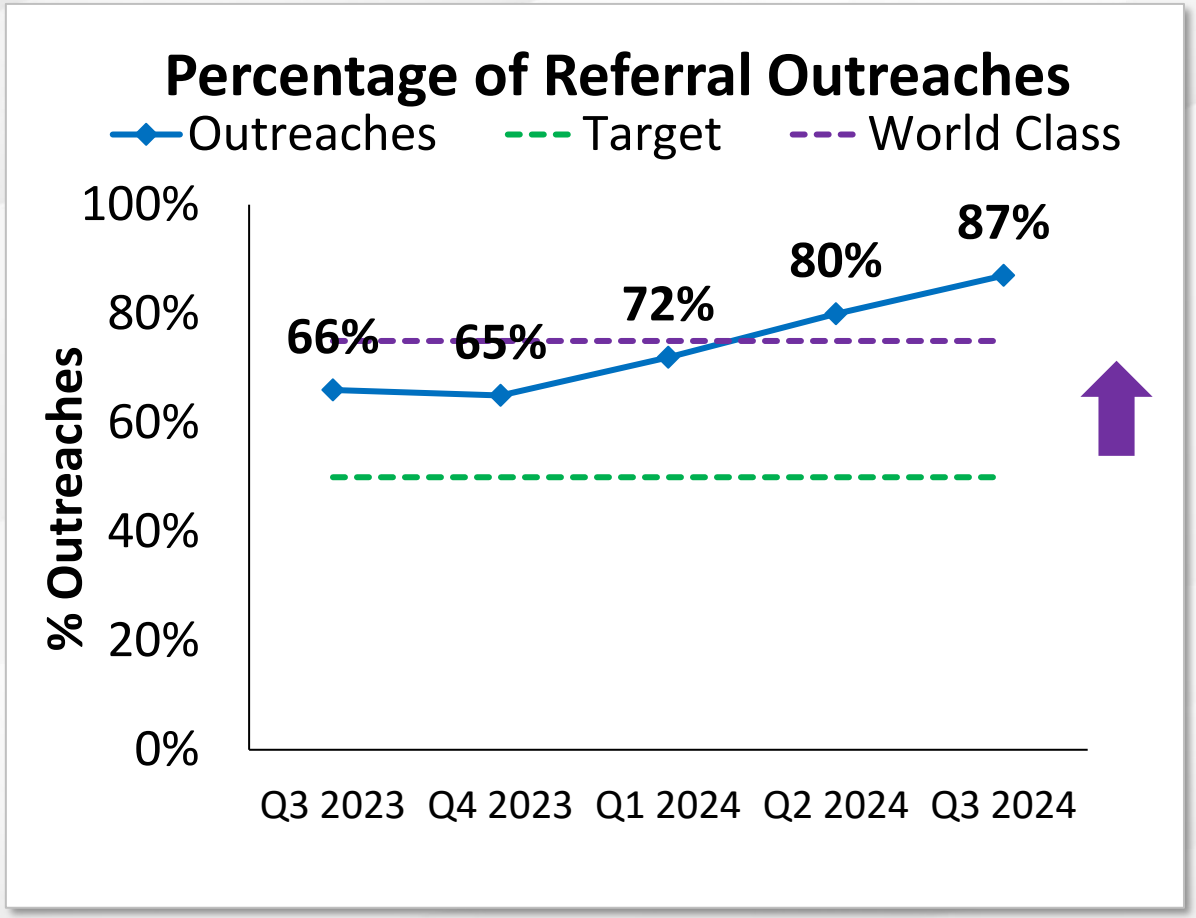
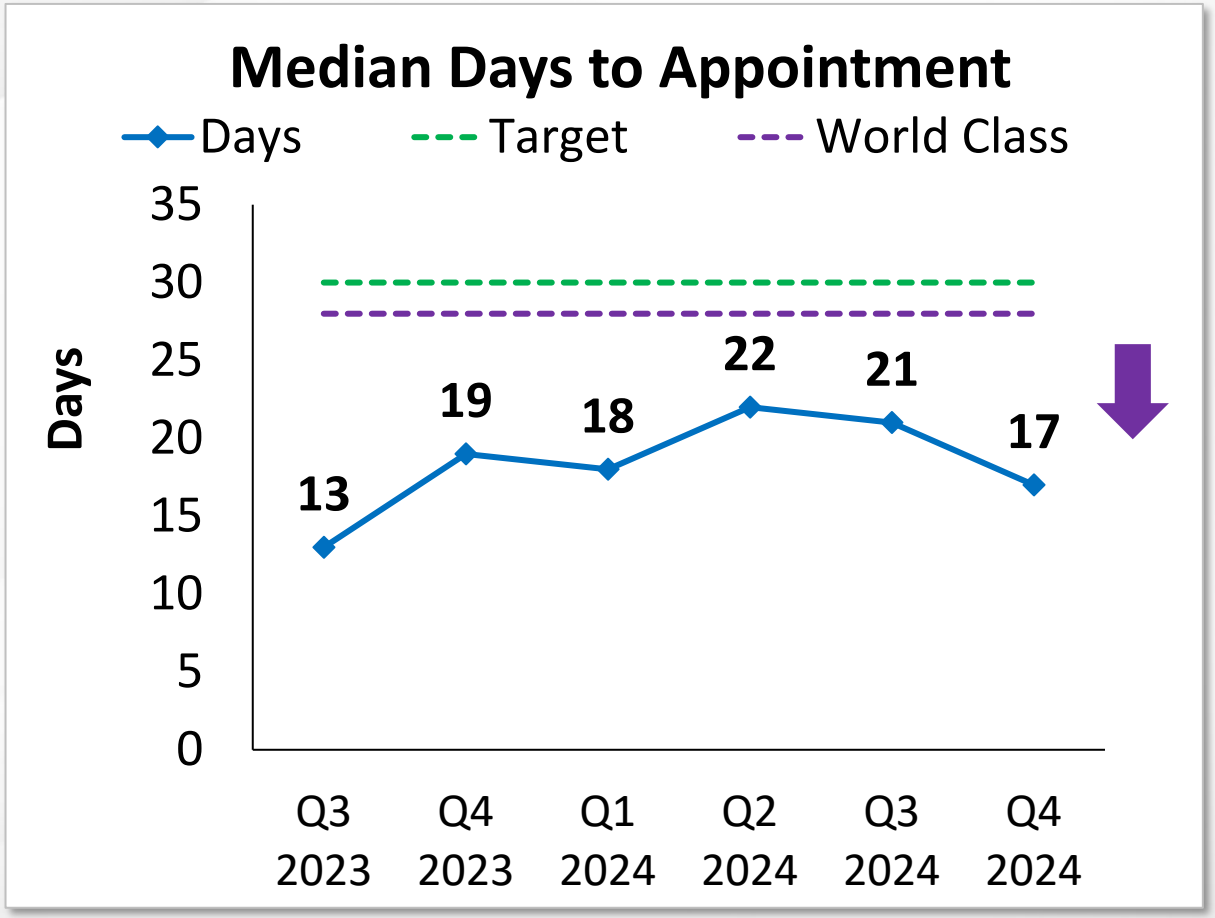
Our Measures of Success





11 days faster than market to appointment through PicassoMD

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Specialty Care Pathway Examples

Direct to Colonoscopy Pathway

What: Partnered with our Physician Alliance member, Capital Digestive Care, to provide appropriate times for direct referral to colonoscopy

Process: Develop process map for seamless care coordination from PCP to Colonoscopy

Outcomes: Reduce unnecessary visits to gastroenterologist and improve colorectal cancer screening rate

Musculoskeletal Pathway

What: Partnered with AHC Rehabilitation to develop appropriate times to refer to PT/OT for low back pain prior to referring to Orthopedics

Process: Develop process map from PCP to PT/OT

Outcomes: Reduce unnecessary visits to Orthopedics to improve access for appropriate referrals and reduce cost for patients

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Looking Ahead

1. Focus on Medical Neighborhood specific initiatives
2. Focus on specialty areas with actionable areas of opportunity
3. Develop dashboards to analyze specialty specific data:
   - In network referral rates
   - Time to appointment
   - In network/out of network practices

Adventist HealthCare

Thank you!

Adventist HealthCare

THANK YOU

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