Central Oregon Health Council

Provider Engagement Panel
PacificSource Community Solutions – Boardroom
2965 NE Conners Ave, Bend OR 97701

Agenda: January 13, 2016 from 7:00am-8:00am

Call-In Number: 866-740-1260
7-Digit Access Code: 3063523

1. 7:00-7:05 **Introductions & Updates—All**

2. 7:05-7:15 **Healthy Hearts Northwest (H2N)—Kristin Chatfield**

3. 7:15-7:55 **Regional Health Improvement Plan Group Feedback (5 minutes for each section)**
   - **Diabetes—Dr. Mills and Dr. Sharma**
   - **CVD—Dr. Sharma**
   - **BH (Screening)—Dr. Pennavaria, Dr. Mann, and Dr. Perryman**
   - **BH (SUD)—Dr. Pierson and Dr. Swanson**
   - **Oral Health—Dr. Allen and Ms. Ludwig**
   - **MCH/RH—Ms. DeLaVergne-Brown and Dr. Pennavaria**
   - **Social Determinants—All**

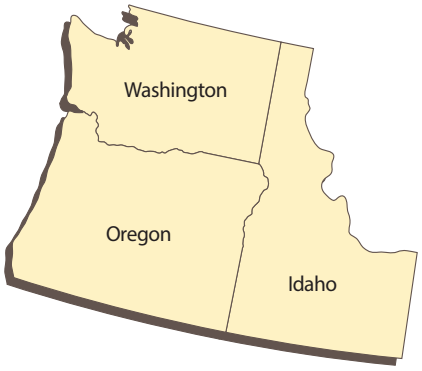
4. 7:55-8:00 **2016 QIM Preparation: Brief Update—Maria Hatcliffe & Rebeckah Berry**

Consent Agenda:

- **Approval of the draft minutes dated December 9, 2015 subject to corrections/legal review**

EvidenceNOW
Advancing Heart Health in Primary Care

Northwest Cooperative



EvidenceNOW: Advancing Heart Health in Primary Care is an initiative of the Agency for Healthcare Research and Quality (AHRQ) to transform health care delivery by building a critical infrastructure to help smaller primary care practices improve the heart health of their patients by applying the latest medical research and tools. EvidenceNOW establishes seven regional cooperatives composed of public and private health partnerships that will provide a variety of quality improvement services typically not available to small primary care practices. The goal of this initiative is to ensure that primary care practices have the evidence they need to help their patients adopt the **ABCS** of cardiovascular disease prevention: **A**spirin in high-risk individuals, **B**lood pressure control, **C**holesterol management, and **S**moking cessation. The initiative also includes an independent national evaluation designed to determine if and how quality improvement support can accelerate the dissemination and implementation of new evidence in primary care.

Cooperative Name:
Healthy Hearts Northwest: Improving Practice Together

Principal Investigator:
Michael L. Parchman, M.D., M.P.H., Group Health Cooperative

Cooperative Partners:
MacColl Center for Health Care Innovation and the Center for Community Health Evaluation, both at Group Health Cooperative

Qualis Health

Oregon Rural Practice-based Research Network (ORPRN) at Oregon Health & Science University

University of Washington School of Medicine

Geographic Area:
Washington, Oregon, Idaho

Project Period:
2015-2018

Region and Population

The Pacific Northwest has a mix of highly agricultural and sparsely populated counties with a growing Hispanic population and large and growing urban centers. Heart health indicators vary considerably across the region. They are worse in small rural counties where primary care has fewer internal quality improvement (QI) resources than in more populated urban areas. For example, heart attack deaths in some small rural counties are almost twice as high as in larger metropolitan counties. In addition, mortality rates from stroke are higher in the region than in the United States as a whole.

Specific Aims

1. Identify, recruit, and conduct baseline assessments in 320 small- to medium-sized primary care practices across Washington, Oregon, and Idaho during the project's first year.
2. Provide comprehensive practice support to build quality improvement capacity within these practices.
3. Disseminate and support the adoption of patient-centered outcomes research (PCOR) findings relevant to aspirin use, blood pressure and cholesterol control, and smoking cessation (ABCS) quality measures.
4. Conduct a rigorous evaluation of strategies that enhance the effectiveness of external practice support to improve QI capacity, implement patient-centered outcomes research findings, and improve ABCS measures.
5. Assess the sustainability of changes made in QI capacity and ABCS improvements and develop a model of scale-up and spread for improving QI capacity in primary care practices.

Reach

- Goal for Number of Primary Care Practices Recruited: 250-320
- Goal for Number of Primary Care Professionals Reached: 750-960
- Goal for Population Reached: 1.13-1.44 million

AHRQ
Agency for Healthcare Research and Quality
Advancing Excellence in Health Care ● www.ahrq.gov
NATIONAL CENTER FOR EXCELLENCE IN PRIMARY CARE RESEARCH

EvidenceNOW
Advancing Heart Health in Primary Care

Northwest Cooperative

Comment from Principal Investigator

Michael Parchman, M.D., M.P.H.

"Our goal is to build a sustainable infrastructure for ongoing improvements in the delivery of primary care in the Pacific Northwest that contributes to the Triple Aim, improves the experiences of those who provide care within the practice, and prepares primary care providers for value-based care reimbursement models. We will make a substantial contribution to the field of implementation science by advancing understanding of how to effectively provide external practice support to build QI capacity and improve cardiovascular risk factors for a substantial number of people served by small- to medium-sized primary care practices."

Notable Project Features

- Project will have significant participation by rural practices.
- Regional design allows the Cooperative to understand how specific State factors affect health care delivery.
- Design will study rapid scale-up and spread of practice support to build QI capacity.

Approach and Methods

Practice Recruitment and Enrollment

Primary recruitment targets are practices that need significant help in building their QI capacity, but have an Office of the National Coordinator 2014 certified electronic health record that can assist with their QI efforts. Target practices will be small (<10 practitioners) and independently owned and operated. Smaller practices affiliated with larger organizations also will be recruited if the larger organizations have limited experience with providing support for primary care QI. The Cooperative will recruit by:

- Reaching out to practices with which the Cooperative already has strong relationships.
- Leveraging relationships within social networks of already-recruited practices and reaching out to members of the Cooperative's State-level organizational partners.

Support Strategy

Each participating practice will receive 15 months of support in two key areas:

- *Health Information Technology Support and Use of Data for Physician Quality Reporting System (PQRS) Reporting and Quality Improvement.* The Cooperative will help the practices improve PQRS reporting of ABCS measures by creating a tailored Action Plan to guide the support. The practices will be divided into three tiers, depending on how experienced they are in PQRS reporting and how much information technology support they need. Health information technology staff will support practices through ongoing phone and secure Internet communication.
- *External Practice Quality Improvement Support.* This support will enhance the practices' capacity to use new PCOR findings to change their care practices and improve ABCS measures. This content will be disseminated to the practices using academic detailing (i.e., educational outreach through self-paced learning modules and phone calls). To build their QI capacity to adopt and implement PCOR heart health findings, practices will be assessed using PCMH Change Concepts and then receive tailored external support through (1) practice facilitation (i.e., a kick-off meeting, face-to-face visits, regular phone calls); (2) shared learning opportunities (i.e., Regional Improvement Collaboratives led by the practice facilitators with monthly phone calls and Webinars); and (3) affinity groups to conduct "deep dives" on improvement work across the smaller regional groups of practices.

Evaluation

Practices will be divided into small regions of 20 practices each. Each small region will be assigned to one of 16 practice facilitators. Each region of practices also will be randomized to one or more strategies hypothesized to enhance the effectiveness of the external practice support for more rapid adoption of PCOR heart health findings and improvement of QI capacity. This design efficiently uses participating practices and enables estimation of interactions between strategies.

Strategies for Disseminating Study Findings and Lessons Learned:

The Cooperative will disseminate findings through an external website, social media, presentations, manuscripts and outreach to key opinion leaders and potential early adopters.

Last updated date: May 13, 2015

Oregon Rural Practice-based Research Network

Project Overview

HEALTHY HEARTS NORTHWEST

Improving practice together

There is a need for building critical infrastructure to help smaller, primary care practices throughout the Pacific Northwest use the latest evidence to improve heart health. Heart health indicators vary considerably across the region. They are worse in small rural counties where primary care has fewer internal quality improvement (QI) resources than in more populated urban areas. For example, heart attack deaths in some small rural counties are almost twice as high as in larger metropolitan counties. In addition, mortality rates from stroke are higher in the region than in the United States as a whole.

Achieving better heart health outcomes for patients is an ongoing priority for the Oregon community. As our healthcare environment continues to evolve rapidly, smaller practices face challenges around the ability to effectively use data and improve quality. This is increasingly important for reimbursement eligibility. Many smaller practices lack the internal resources for optimizing health information technology (HIT) and building QI capacity.

Healthy Hearts Northwest: Improving Practice Together (H2N) is part of EvidenceNOW, the AHRQ grant initiative to transform health care delivery. With partners Qualis Health, and the MacColl Center for Health Care Innovation (recipient of the AHRQ funding for this initiative and H2N PI office), the Oregon Rural Practice-based Research Network (ORPRN) at the Oregon Health & Science University (OHSU) will select 130 small- and medium-sized primary care practices throughout Oregon to participate in H2N. ORPRN seeks to help these practice build their quality improvement (QI) capabilities and infrastructure, and to transform practices into learning organizations that engage in sustained, continuous, systematic QI. The practices will learn practical strategies that can strengthen their organizations and restore the joy to primary care. The initial focus of H2N will be implementing Patient-Centered Outcomes Research (PCOR) to improve heart health, as described within the Million Hearts campaign related to **ABCS**: **A**spirin, **B**lood pressure, **C**holesterol and **S**moking cessation.

Over the course of 15 months, ORPRN will:

1. Provide a Practice Enhancement Research Coordinator (PERC) to support improving ABCS heart health measures, including how to use EHRs for QI purposes. The PERC will visit the practice regularly, with monthly calls in between visits, and will be accessible by phone.
2. Assist with producing reports of ABCS clinical quality measures.
3. Provide benchmark reports on ABCS clinical quality performance measures to the practice on each measure, with benchmarks at a regional, state, and national level.
4. Provide high-value information about how to participate in value-based reimbursement programs, such as PQRS and meaningful use.
5. Provide survey results back to the practice that indicate opportunities for improving QI infrastructure.
6. Conduct webinars every other month to assist practices with meeting H2N improvement milestones.
7. Convene phone-based office hours to discuss different topics and share lessons learned.
8. Support participation in this study as meeting ABFM and ABIM MOC Part IV requirements.
9. (For those selected) Identify and coordinate a site visit to an exemplar practice.
10. (For those selected) Provide training in the use of evidence-based cardiovascular risk reduction calculation and care planning.
11. Keep the practice informed about the overall study. We want to help participating practices as much as we can, so we may adjust specific aspects as the study progresses.

GroupHealth

MacColl Center for Health Care Innovation

ORPRN Oregon Rural Practice-Based Research Network

QUALIS HEALTH

WPRN Collaborative Research. Innovative Care.

The practice agrees to improve ABCS performance measures and will:

1. Schedule a two-hour, in-person "Welcome visit" with a PERC.
2. Complete surveys at 3 time points: upon project enrollment, at the end of the 15 months of practice support, and 6 months after completing 15 months of practice support:
   a. A practice or clinic-level survey completed by a practice manager or leader.
   b. A survey completed by all clinicians and staff who work in the practice.
3. Designate a "Healthy Hearts Champion", usually a physician or non-physician (nurse practitioner or physician assistant) clinician and a point of contact for the H2N project team.
4. Convene a Healthy Hearts Improvement Team of at least three individuals comprising the Healthy Hearts Champion and a representative from the front and back office.
5. Provide protected time for the Healthy Hearts Improvement Team to meet internally weekly to develop and work on improvement milestones and conduct small cycle tests of change to improve ABCS heart health measures.
6. In addition to the internal Improvement Team meeting, at least two members of the Improvement Team will:
   a. Participate in face-to-face visits or a monthly phone call with the PERC.
   b. Attend a Healthy Hearts Webinar with all practices across the 3 states for one hour every other month.
   c. Participate in phone-based office hours.
7. Collect and provide the study team with aggregate practice-level data (unique to each practice location) on clinical quality measures related to aspirin use, blood pressure control, cholesterol control, and smoking cessation (ABCS) quarterly from enrollment until April 30, 2018.
8. (For those selected) At least two individuals from the practice will conduct a one-day site visit to an exemplar clinic within the first 12 months after enrollment.
9. (For those selected) Clinicians, nurses, and medical assistants will participate in training on the effective use of a cardiovascular risk calculator.
10. Agree to be (publically) recognized as a participant in this project.

Please contact ORPRN's H2N project manager, Caitlin Dickinson, at summerca@ohsu.edu or 503-494-9106. More information about H2N is available http://www.ohsu.edu/xd/outreach/oregon-rural-practice-based-research-network/.

Quality Measures Crosswalk – Million Hearts and Other Incentive Programs

BLUE = Required GREEN = Optional

Million Hearts Domain	Million Hearts Clinical Quality Measure	CMS Physician Quality Reporting System (PQRS)	CPC 2015 eCQMs	CMS EHR Incentive Program (MU)	PCPCH	CCO Incentive eCQMs	UDS	ACO Medicare Shared Savings Program (SSP)
Aspirin When Appropriate **NQF: #0068**	**Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic** Percentage of patients aged 18 years and older who were discharged for AMI/CABG/PCI **OR** diagnosed with IVD **AND** documented use of aspirin or other antithrombotic	**Yes**	No	**Yes**	No	No	**Yes**	**Yes**
Blood Pressure Control **NQF: #0018**	**Hypertension (HTN): Controlling High Blood Pressure** Percentage of patients aged 18 through 85 years who had a diagnosis of HTN **AND** whose blood pressure was adequately controlled (<140/90) during the most recent visit in the measurement year	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**
Cholesterol Management **NQF: n/a**	**Cholesterol— Statin Therapy for the Prevention and Treatment of Cardiovascular Disease** Patients who are at high risk of cardiovascular events who were prescribed or are on a statin. **High Risk definition categories** 1. Patients >= 21 years of age who were previously diagnosed	No	No	No	No	No	No	No
Smoking Cessation **NQF: #0028**	**Preventive Care and Screening: Tobacco Use** Percentage of patients aged 18 years and older who had two visits or one preventive care visit within 24 months who were screened about tobacco use one or more times **AND** who received cessation counseling intervention if identified as a tobacco user	**Yes**	**Yes**	**Yes**	**Yes**	**Yes** - as of 2016	**Yes**	**Yes**

MINUTES OF A MEETING OF
PROVIDER ENGAGEMENT PANEL
CENTRAL OREGON HEALTH COUNCIL
December 9, 2015 from 7-8:00am – PacificSource Boardroom

Members Present (In-Person)
Steve Mann, Chair (COIPA and High Lakes Healthcare)
Gary Allen (Advantage Dental)
Rebeckah Berry (COHC)
Maria Hatcliffe (PacificSource)
Alison Little (PacificSource)
Donna Mills (COHC)
Kyle Mills (Mosaic Medical)
Laura Pennavaria (La Pine Community Health Center)
Dana Perryman (COPA)
Christine Pierson (Mosaic Medical)
Divya Sharma (Mosaic Medical and COIPA)

Members Present (Call-in)
Sharity Ludwig (Advantage Dental)

Guests Present
Angela Saraceno (Healthy Beginnings)
Holly Remer (Healthy Beginnings)
Randy Moss (American Medical Transit)

Absent:
Sheila Albeke (PacificSource)
David Holloway (Bend Memorial Clinic)
Jennifer Laughlin (St. Charles Medical Group)
Rob Ross (St. Charles Medical Group)
Kim Swanson (St. Charles Medical Group)

Introductions

- Dr. Mann welcomed all attendees and guests were introduced.

Healthy Beginnings Overview

- Holly Remer of Healthy Beginnings presented to the group. She explained that they see themselves as a gateway program. They recruit volunteers from the community including RNs and specialists to provide one-on-one screening, referral and parent education using evidence-based assessment tools such as ASQ. They require the parent to always be present and there are no eligibility requirements.
- Ms. Remer explained that they have 18 full-day screening clinics per year in all of Central Oregon. She shared that 40% of children do not enter Kindergarten "prepared to learn."
- Healthy Beginnings reports that they are strong in referrals to community services. They collaborate with the High Desert Education Service District, United Way of Deschutes County, EL HUB, and OSU – Cascades. They receive referrals from various avenues in the community such as schools, homeless shelters, WIC, FAN, DHS, among many others.
- Ms. Remer explained that they are always in need of volunteer professionals.
- She explained that the population has a lack of understanding of the importance of these screenings. Of the 697 children that were screened last year, 631 of those screenings identified concerns. Additionally, over 1/3 of children had not seen a dentist.
- Ms. Remer also noted that HB has sustained an 8-year partnership with OHA to provide OHP Application Assistance.
- Dr. Allen requested a breakdown of the numbers for each type of care. Ms. Remer stated that this was possible and that the rates in dental are the highest. They have a goal to increase the amount of child screenings that they refer to as "4 B4 5" which consists of health, behavioral, vision, and dental).
- Dr. Allen asked why this has program has not caught on more in Oregon and other areas. Ms. Remer stated that they believe it is relative to funding and the need for a volunteer coordinator as well as office space.
- Dr. Little asked what there target age is. Ms. Remer responded that they target birth to 5 years with some exceptions.
- Ms. Hatcliffe noted that many of these children that are screened are not yet insured. Ms. Remer confirmed this information and stated that they would like for PCPs to make referrals because they are able to provide more in-depth screenings. She referred the group to their website www.myhb.org and said that they do try to help children get connected with a PCP when there is none.

ACTION: Holly will email Rebeckah screening dates and Rebeckah will share with all COHC contacts in the future.

Assignment of RHIP Priority Review

- Dr. Mann reviewed the priority areas with the PEP and noted the clinical experts that have been assigned to each area:

- Reproductive and Maternal Child Health: Muriel DeLaVerge-Brown & Laura Pennavaria
- Diabetes: Kyle Mills & Divya Sharma
- Behavioral Health:
  - Identification and Awareness: Laura Pennavaria, Steve Mann, and Dana Perryman
  - Substance Abuse and Chronic Pain: Christine Pierson & Kim Swanson
- Cardiovascular Disease: Divya Sharma
- Oral Health: Gary Allen and Sharity Ludwig

Action: Each group will review their portion of the RHIP and come prepared to present their feedback to the group at January's meeting (1.13.16).

QHOC Monthly Update

- Dr. Little informed the group that syphilis screenings have increased among both males and females, noting that there were 4 cases of congenital syphilis in 2015. OHA has new syphilis screening recommendations based on the increase in prenatal/congenital syphilis. They recommend screening all pregnant women for syphilis at their first prenatal visit, at the beginning of the 3rd trimester, and again at delivery.
- Dr. Little reported that there is a new Chief Health Systems Officer, Dr. Varsha Chauhan.
- Regarding out of hospital births, Dr. Little shared that CCOs will now be notified when a member moves to FFS for an OOH birth pregnancy. She shared the following highlights:
  - More than 800 members have asked for OOH birth (50% of these need to submit additional information related to risk and 25% have not been approved because they are not low risk).
  - HERC will be finalizing the coverage guidance on Nov 12 and OHA will be following the outcomes.
  - There is no newborn care reimbursement to providers following an OOH birth (the newborn must be referred back under CCO care); mother comes back to CCO after 60 days PP.
  - Issue of adverse selection was again raised. The OHA representative determined that QHOC was not the forum to address this issue, and that it will be discussed with CCO contractors (regarding additional reimbursement to address adverse selection).
- HERC is looking at the effectiveness of a treatment and making recommendations around the back pain guidelines. If the treatment results in >1% cost increase, actuarial services need to evaluate the impact.
- MRI guideline modifications are coming and feedback is being sought. Right now it reads so that anyone with back pain >4 weeks could receive an MRI.
- Guideline note 127 gender dysphoria is finalized.
- OOH Birth is not finished. They are still defining what needs to be demonstrated/ruled out. US will be required.

- Indications for Proton Beam Therapy. Pediatric cancers are being added because it decreases the risk of secondary malignancies. They are still determining what lines it should be added to. Deleting from thoracic lines. They are unsure yet regarding brain tumors.
- Healthy Hearts Northwest. AHRQ grant initiative to transform health care delivery. ORPRN will select 1230 small- and medium-sized primary care practices throughout Oregon to participate in H2N. Practices need to have 10 FTE or fewer.
- During the presentation by the Immunization Program of the Public Health Division, a draft document titled "Evidence-based Strategies for Improving Childhood Immunization Rates: A Guide for CCO's" was distributed and feedback was requested.

  ACTION: Rebeckah will send Think Out Loud link to PEP and PSTF

- There will be no HERC meeting in December.

Consent Agenda

- Dr. Mann made a motion to accept the minutes dated November 11, 2015. The minutes were approved and accepted in full.