MGP Quality Improvement Central VT Medical Center

October 2014 - Blueprint for Health Semi-Annual Conference

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Objectives

- Define Key CVMC MGP Quality Initiatives
- Examine Quality Infrastructure
- Review Initiative Alignment & Quality Improvement Work Plan
- Demonstrate Recent Successes

MGP Key Quality Initiatives

- National Committee for Quality Assurance Patient Centered Medical Home (NCQA PCMH) 2014 Standards
- Accountable Care Organization, One Care Vermont (OCV), Commercial and Medicaid
- Meaningful Use (MU) Stage 2

Quality Infrastructure

- Blueprint for Health/One Care Vermont
- Medical Group Quality Sub-Committee
- Medical Group Management Committee
- Practice Quality Improvement Teams

Blueprint/ACO Alignment

- One of the Project Manager Blueprint grant deliverables is active participation in ACO planning and other health reform activities.
- The Project Manager shall work to collaborate with the Practice Facilitator(s) and ACO's to promote quality improvement.
- The Grantee shall interact on a regular basis with advisors and community partners for ongoing planning, development, and expansion of CHT's, who shall be representatives of local community health and human services agencies, ACO's, and other stakeholders.

Blueprint for Health

+

ACO's

=

High Quality Care Forever

Alignment of Meetings

- OneCareVermont – Regional Clinical Performance Committee (RCPC)
- Blueprint – Integrated Health Services Workgroup (IHS)

RCPC Defined

The vehicle by which clinical dialogue occurs and decisions are made at the community level to develop and continually enhance the OneCare Vermont ACO Clinical Model. Each Health Service Area (HSA) is expected to form a RCPC. RCPCs, where possible, are encouraged to **leverage existing committees**. The RCPC is made up of ACO participants and affiliates.

IHS Defined

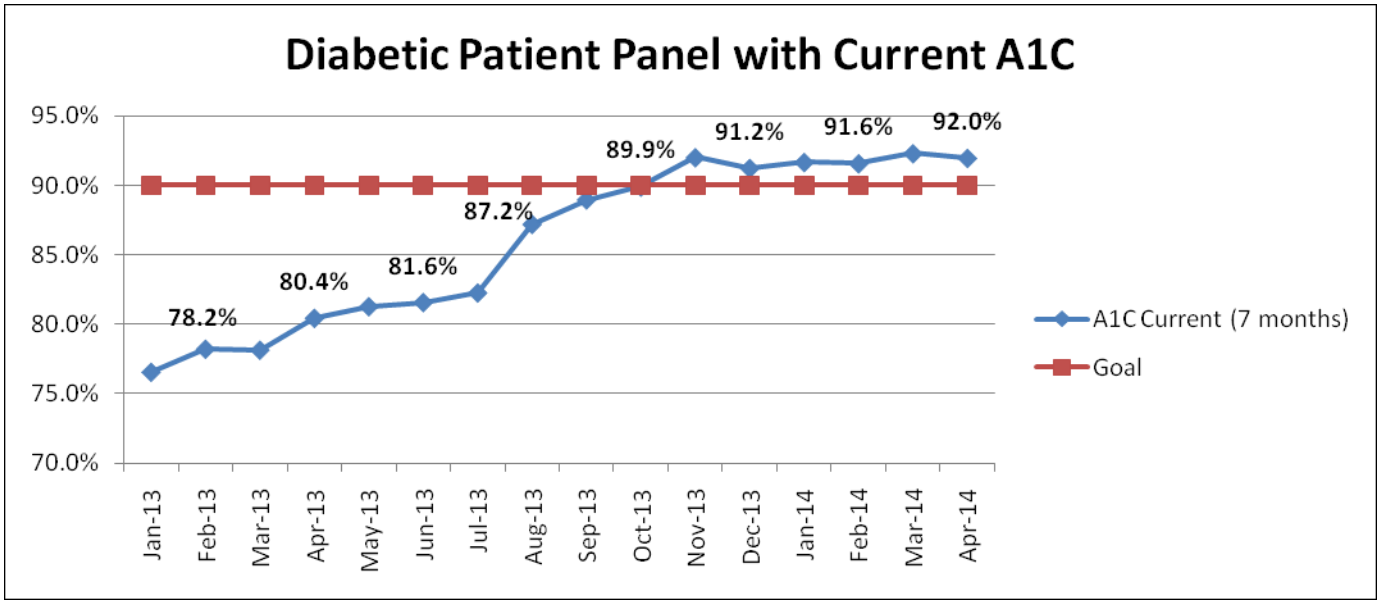
A multi-stakeholder group working together to plan strategies for transitions of care and well-coordinated health services (medical and non-medical). The workgroup will use community assessments to identify gaps in primary care and the surrounding community, and based upon the information obtained, will determine how existing services can be reorganized, and what new services are required to meet the needs and patients and care providers.

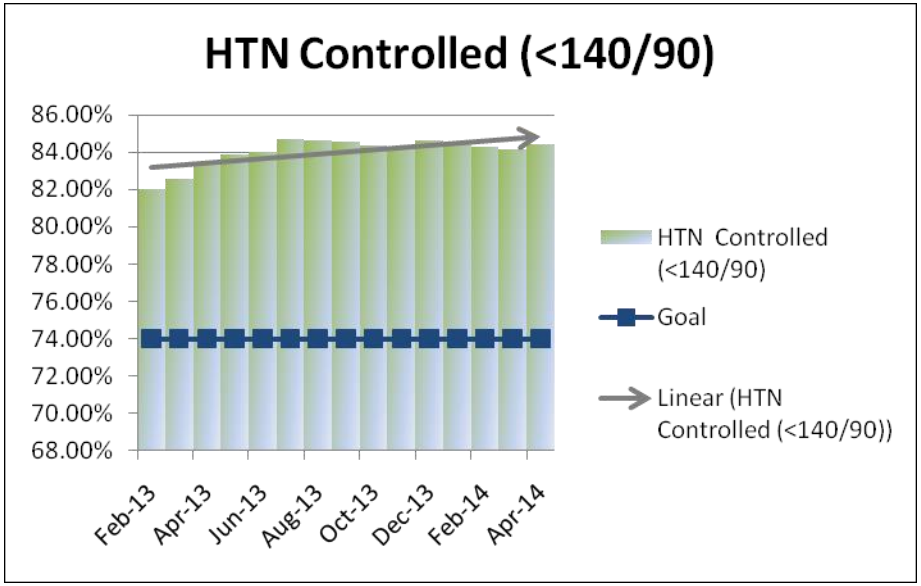
Utilization of Data for Population Management

- PCMH Standard 3D

"Practice proactively identifies populations of patients and reminds them of needed care based on patient information, clinical data, health assessments, and evidence-based guidelines."

Panel Management Successes 2013-14





Initiative Alignment

NCQA PCMH

- 2 Immunizations

ACO &/or MU

- Pneumovax
- Influenza

Initiative Alignment

NCQA PCMH

- 2 Preventative Services

ACO &/or MU

- Mammography
- Colorectal Screening
- BMI Screening & Follow up
- Tobacco Screening & Cessation Intervention
- High Blood Pressure Screening
- Chlamydia Screening
- Developmental Screening (1st 3 years of life)

Initiative Alignment

NCQA PCMH

- 3 Chronic Care Services
- Patients Not Recently Seen

ACO &/or MU

- Diabetes Blood Sugar Control HbA1c <8
- Diabetes Cholesterol Control LDL<100
- Diabetes Blood Pressure Control <140/90
- Hypertension, Blood Pressure Control <140/90
- Coronary Artery Disease, Cholesterol Control LDL<100
- Many others

Clinical Decision Support

- PCMH Standard 3E

"Practice implements clinical decision support (e.g. point-of-care reminders) following evidence based guidelines."

Initiative Alignment

NCQA PCMH

- Behavioral Health or Substance Abuse

ACO &/or MU

- Depression Screening & Follow up
- Initiation & Engagement of Alcohol & other Drug Dependence Treatment

Initiative Alignment

NCQA PCMH	ACO &/or MU
• Chronic Medical Condition	• Diabetes • Heart Failure • COPD • CAD • Asthma

Initiative Alignment

NCQA PCMH

- Condition Related to Unhealthy Behaviors

ACO &/or MU

- Tobacco Screening & Cessation Intervention
- BMI Screening & Follow up

Initiative Alignment

NCQA PCMH

- Overuse/Appropriateness

ACO &/or MU

- Low Back Imaging
- www.choosingwisely.org
- Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis

Care Management & Support

- PCMH 4A

"The practice systematically identifies individual patients and plans, manages, and coordinates care, based on need."

Initiative Alignment

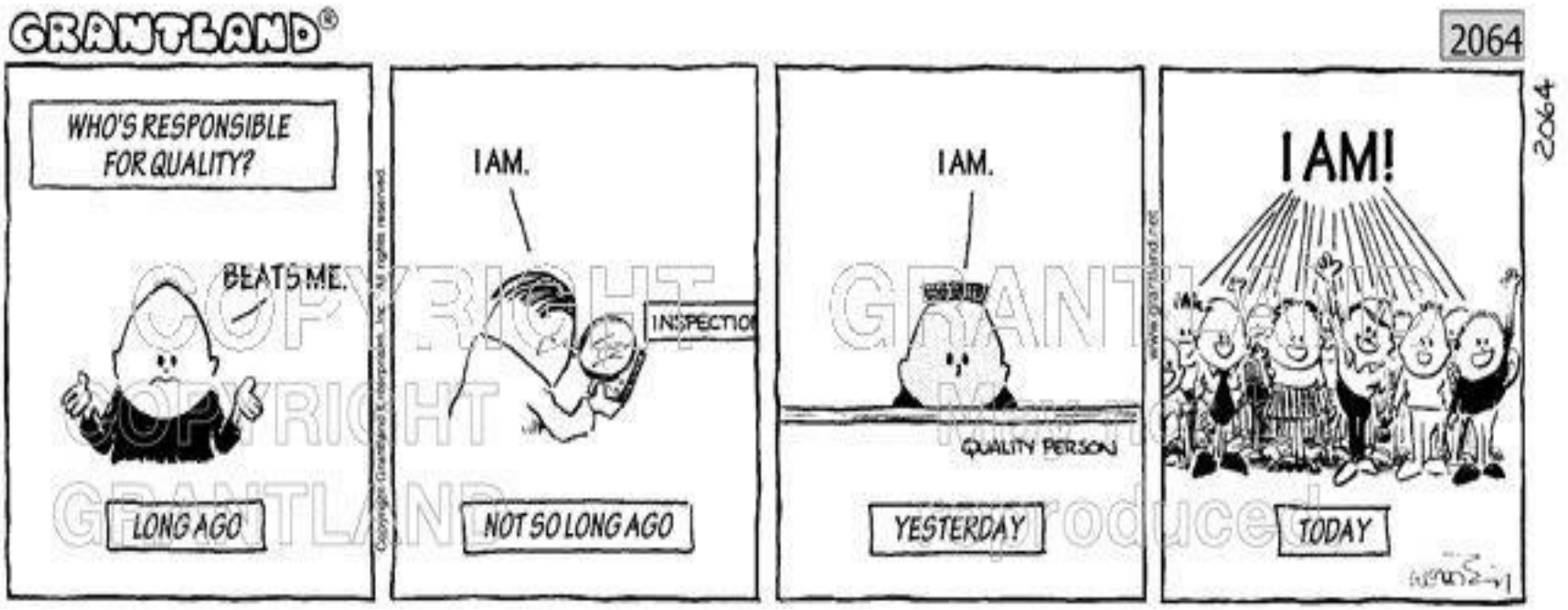
NCQA PCMH

- Behavioral Health Condition
- High Cost/High Utilization
- Poorly Controlled/Complex Conditions
- Social Determinants of Health
- Referrals by Practice Staff or Outside Agencies

ACO &/or MU

- Inpatient Readmissions
- Admissions for Asthma, COPD, or Heart Failure
- Diabetes Poor Control, HbA1c>9

Questions?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WHO'S RESPONSIBLE FOR QUALITY?
BEATS ME.
LONG AGO
I AM.
NOT SO LONG AGO
I AM.
QUALITY PERSON
YESTERDAY
I AM!
TODAY
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