

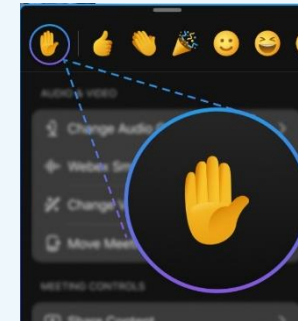
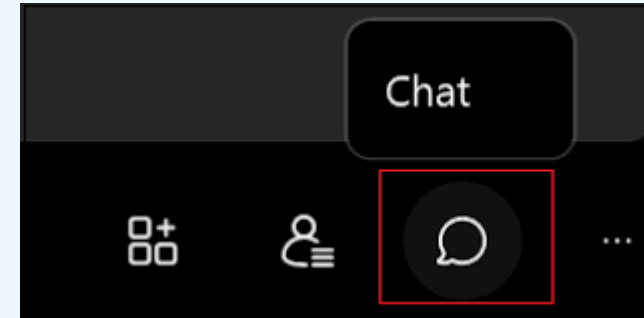


JH QI Training: Introduction to Healthcare Improvement

Beth Careyva, MD MHSA FAAFP
Enterprise Medical Director, Value-Based Care &
Quality Improvement

Virtual Format

- Interactive - as much as we can within time frame
- Chat feature - Please use this!
- Hands / exclamations - Encouraged!



Chat feature discussion

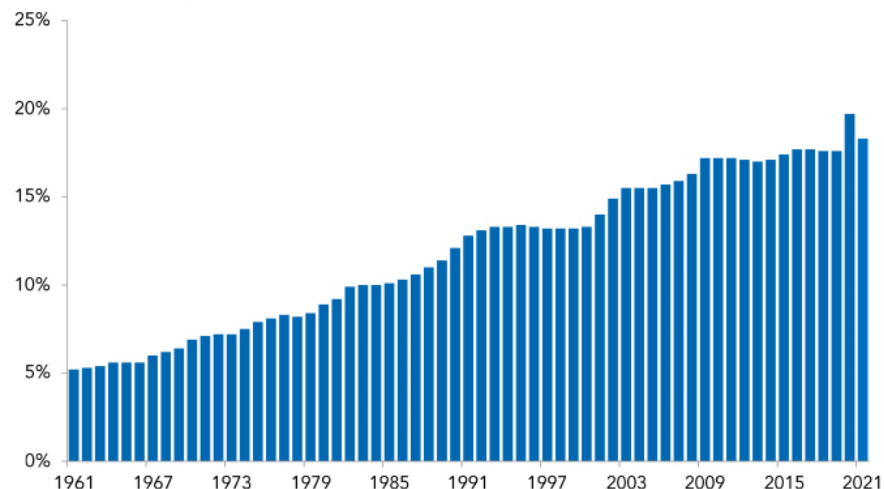
- *One word - how are you feeling about starting this program?*
- My word about YOU starting this program:
 - ***Excited!***
 - It is great to see all of you engaged in this learning program
 - *You are the leaders of today and tomorrow - this education will prepare you to meet the needs of healthcare transformation*

Starting with “Why”



Healthcare costs in the United States have increased drastically over the past several decades

National Health Expenditures (% of GDP)



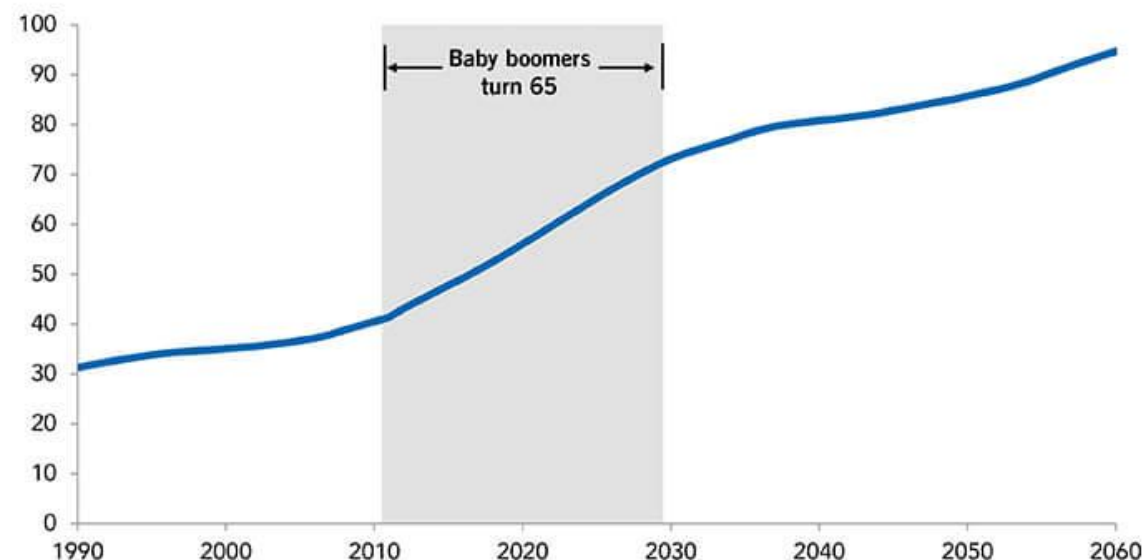
SOURCE: Centers for Medicare and Medicaid Services, National Health Expenditure Data, December 2022.
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PGPF.ORG



The aging of the Baby Boom Generation will boost the number of Americans age 65 and older

NUMBER OF PEOPLE AGE 65 AND OLDER (MILLIONS)



SOURCES: U.S. Census Bureau, National Intercensal Estimates; 2016 Population Estimates; June 2017; and 2017 National Population Projections, September 2018. Compiled by PGPF.

NOTE: The highlighted period represents the time span between the years when the oldest and when the youngest of the Baby Boom Generation turn age 65.

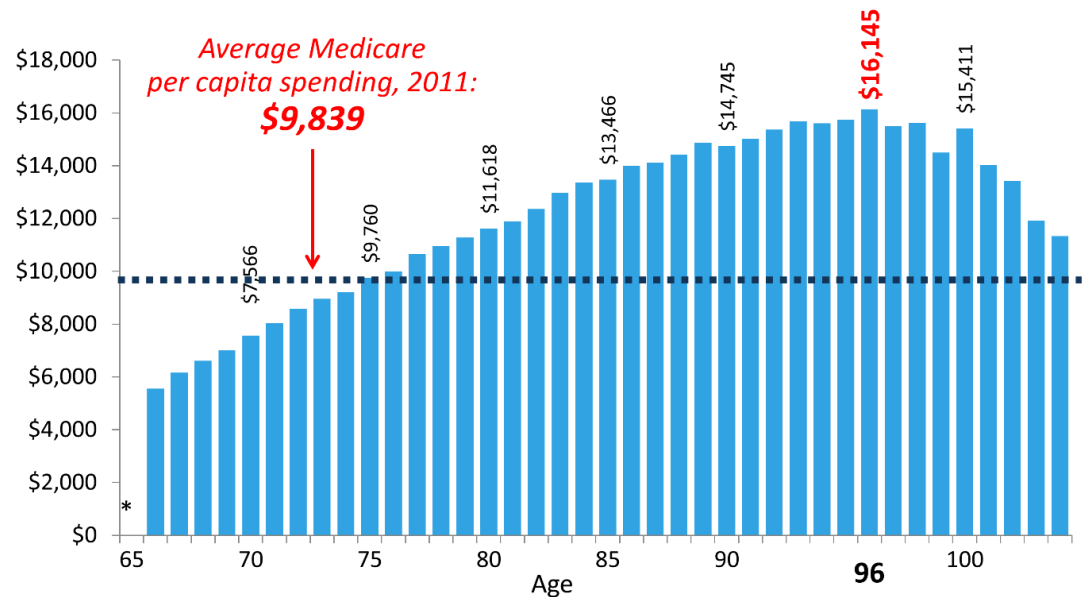
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PGPF.ORG



Starting with “WHY”

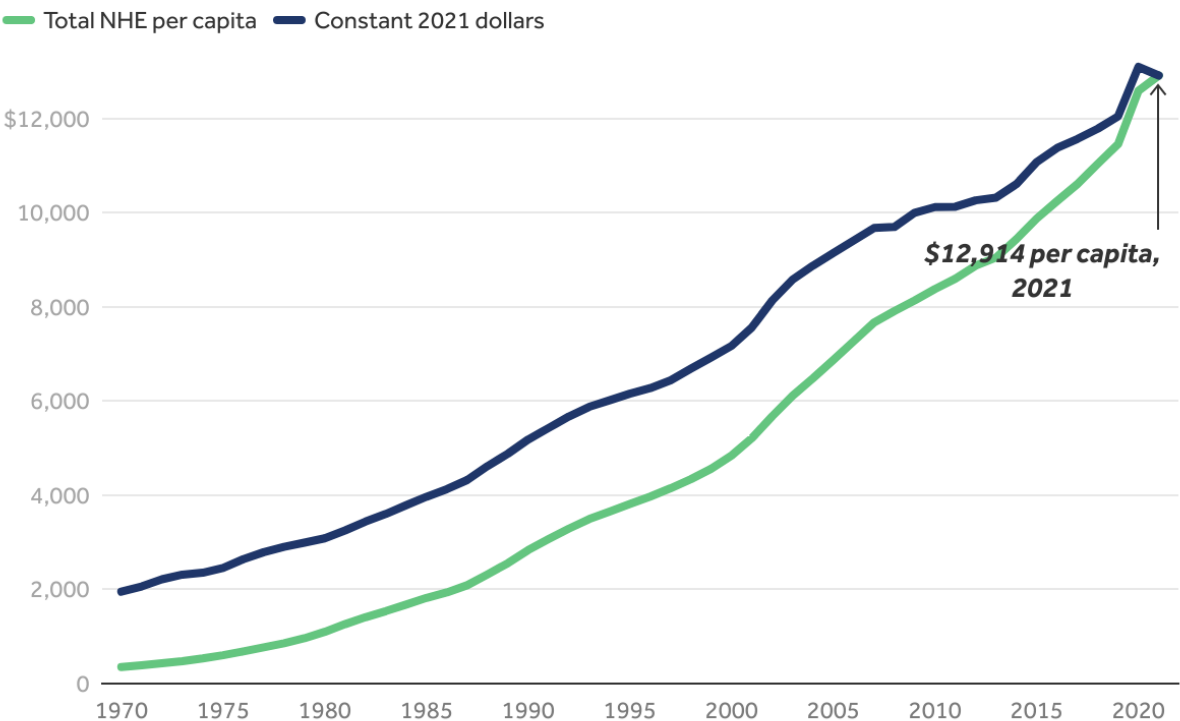
Medicare per capita spending rises with age, peaking at age 96, raising questions about cost and quality



NOTE: Analysis includes beneficiaries in traditional Medicare only (excludes beneficiaries with Medicare Advantage).
SOURCE: Kaiser Family Foundation, “The Rising Cost of Living Longer: Analysis of Medicare Spending by Age for Beneficiaries in Traditional Medicare,” January 2015.



Total national health expenditures, US \$ per capita, 1970-2021



Note: A constant dollar is an inflation adjusted value used to compare dollar values from one period to another.

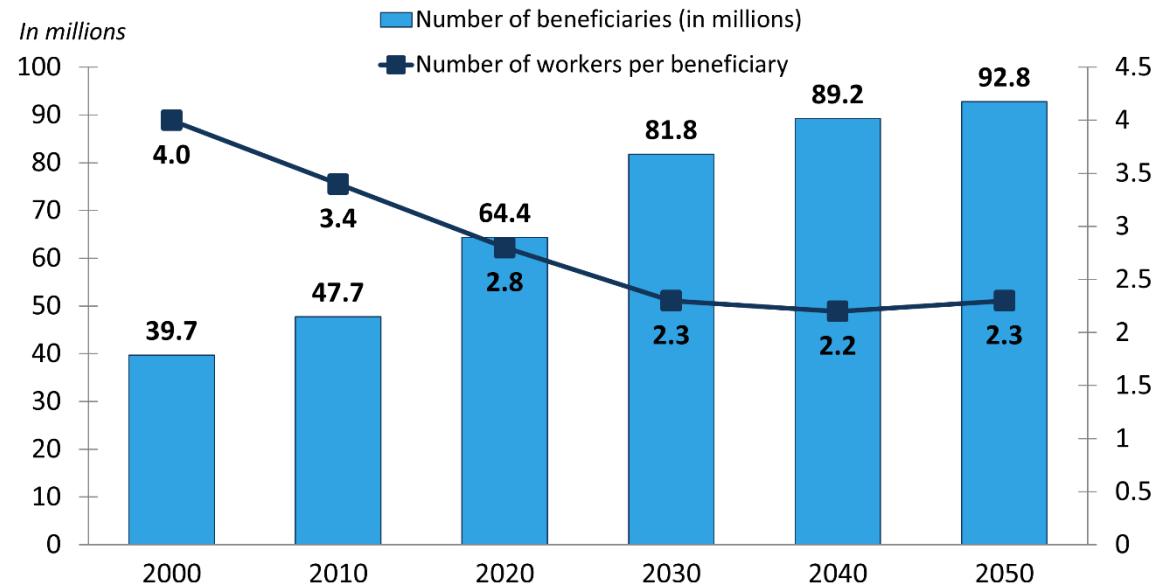
Source: KFF analysis of National Health Expenditure (NHE) data

Peterson-KFF
Health System Tracker

Starting with “WHY”

Figure 31

Number of Medicare Beneficiaries and Number of Workers Per Beneficiary, 2000-2050



SOURCE: Kaiser Family Foundation based on the 2014 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

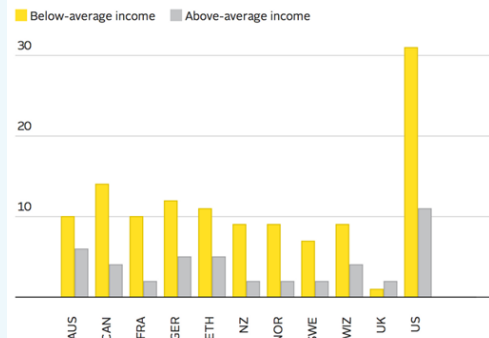


- Price increases, rather than increased utilization, are the primary driver of increased spend

What About Quality?

America's health care system is the least equal

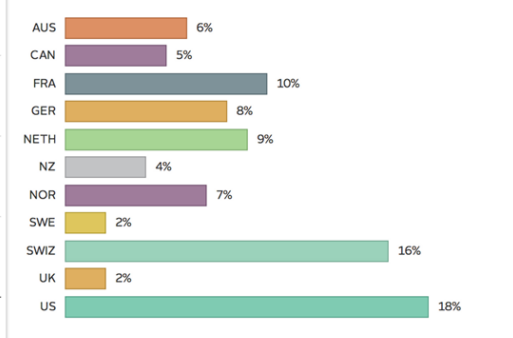
Percent of patients who "did not get recommended test, treatment, or follow-up because of cost in the past year."



Source: The Commonwealth Fund

America has the least efficient health care system

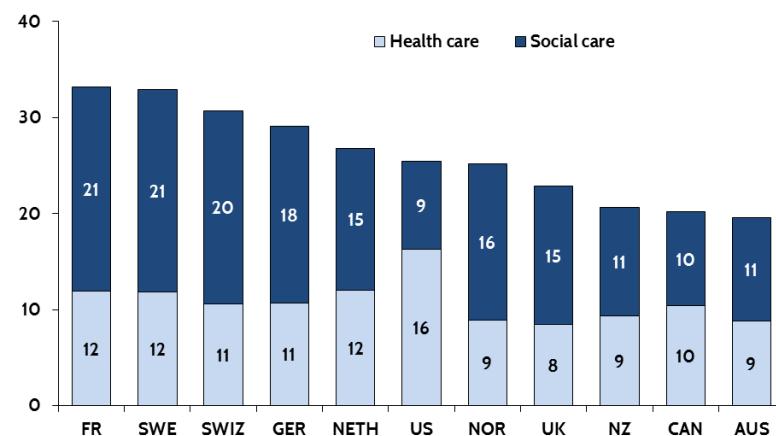
Percent of patients who reported spending "a lot of time on paperwork or disputes related to medical bills"



Source: The Commonwealth Fund

Exhibit 8. Health and Social Care Spending as a Percentage of GDP

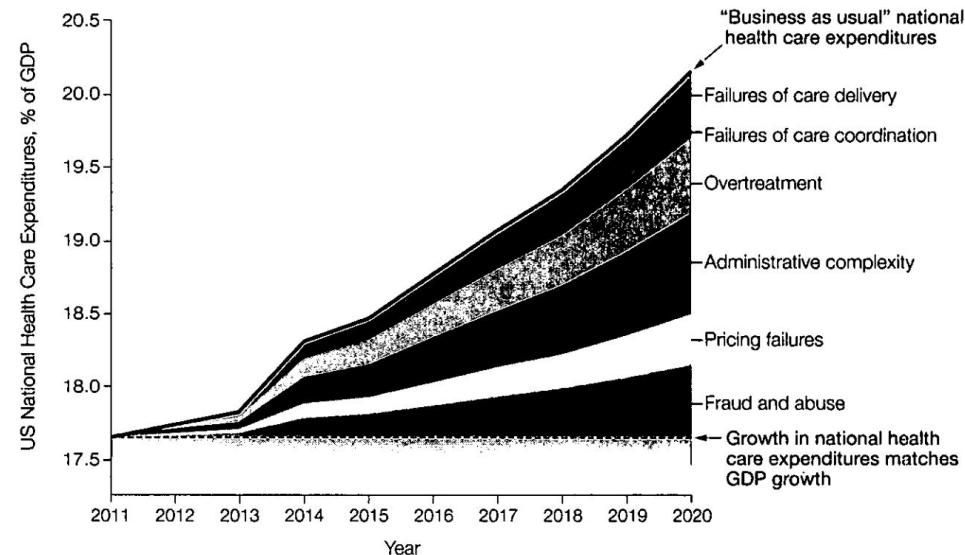
Percent



Notes: GDP refers to gross domestic product.

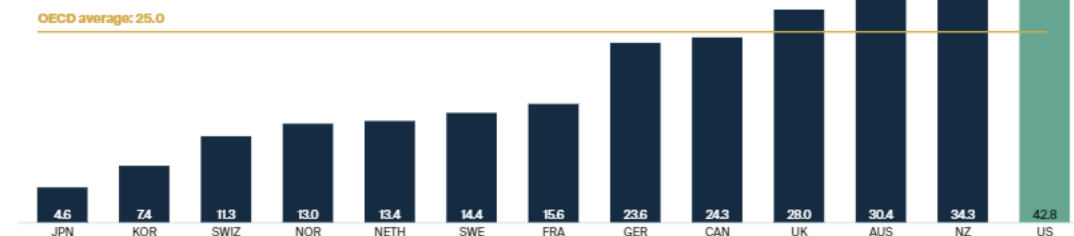
Source: E. H. Bradley and L. A. Taylor, *The American Health Care Paradox: Why Spending More Is Getting Us Less*, Public Affairs, 2013.

Figure. Proposed "Wedges" Model for US Health Care, With Theoretical Spending Reduction Targets for 6 Categories of Waste



The U.S. obesity rate is nearly double the OECD average.

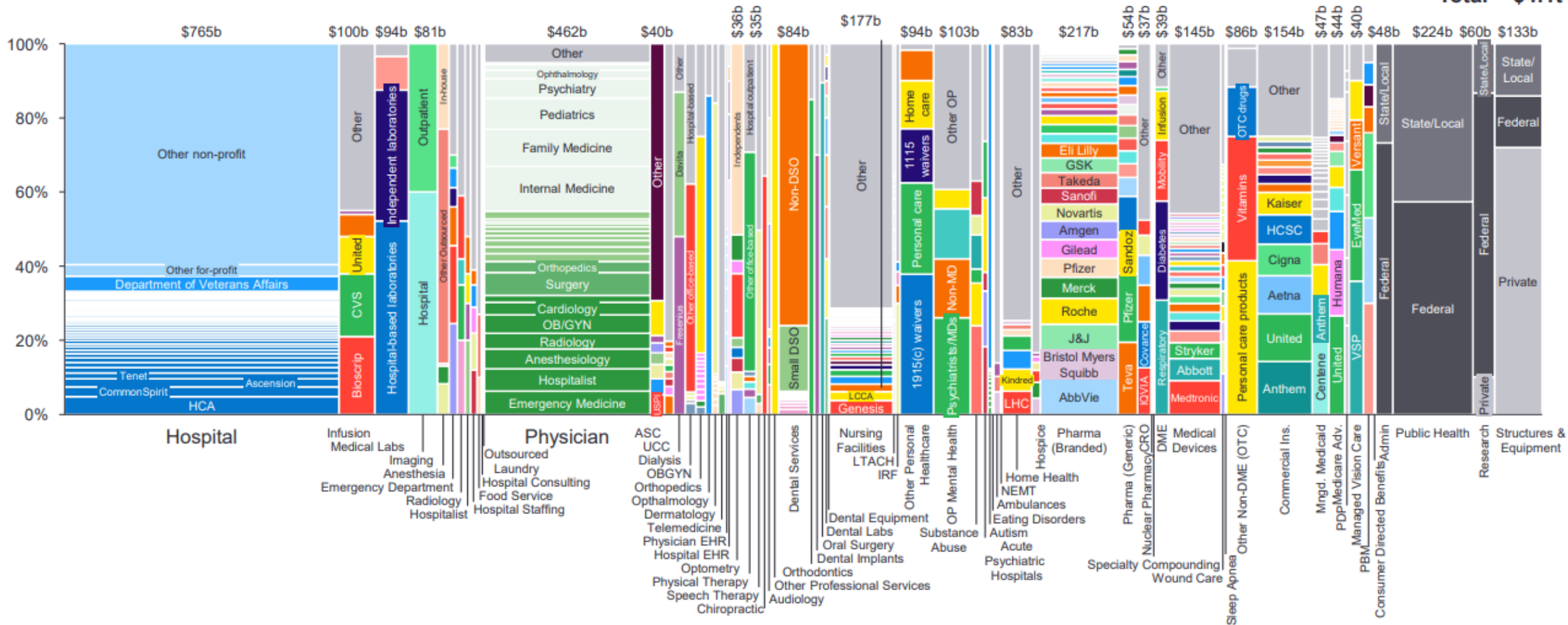
Percent of total population that is obese



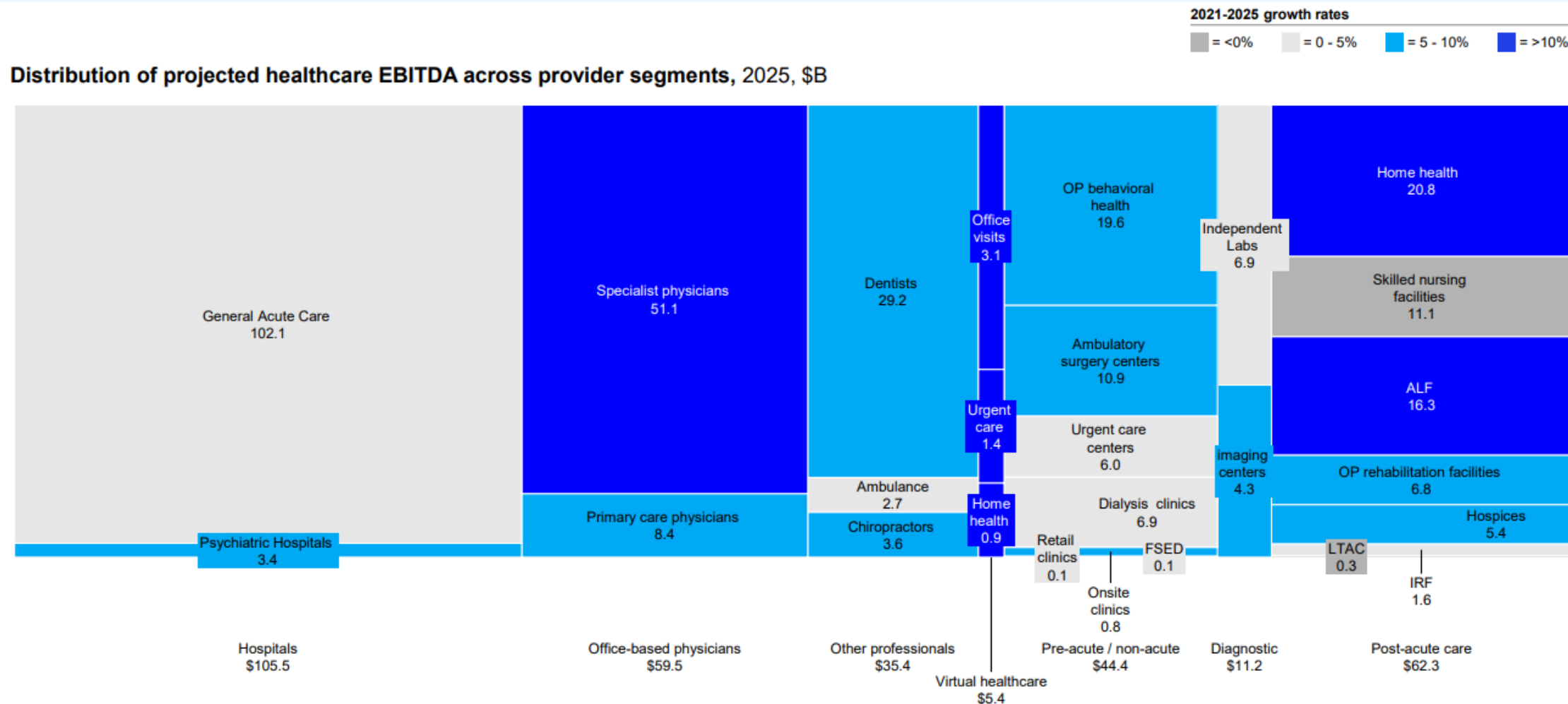
Notes: Obese defined as body-mass index of 30 kg/m² or more. Data reflect rates based on measurements of height and weight, except NETH, NOR, SWE, SWIZ, for which data are self-reported. (Self-reported rates tend to be lower than measured rates.) 2021 data for NZ, 2020 data for KOR, NETH, and SWE, 2019 data for CAN, JPN, NOR, UK, and US, 2017 data for AUS, FRA, and SWIZ, 2012 data for GER. OECD average reflects the average of 23 OECD member countries, including ones not shown here, which provide data on obesity rates.

Data: OECD Health Statistics 2022.

Source: Munira Z. Gunja, Evan D. Gumas, and Reginald D. Williams II, *U.S. Health Care from a Global Perspective*, 2022; *Accelerating Spending, Worsening Outcomes* (Commonwealth Fund, Jan. 2023). <https://doi.org/10.26099/8ejy-yc74>



Healthcare = A Shifting Industry



Source: McKinsey Profit Pools Model

Note : FSED – Freestanding Emergency Department; ALF – Assisted Living Facilities; Hospice – includes palliative care centers; IRF – Inpatient Rehabilitation Facilities; LTAC – Long Term Acute Care Hospitals

McKinsey & Company

8



Chat feature discussion

- *Reflect on your clinical experiences and all you know of our overall healthcare system...*
- Keep it at just a few words if you can
- Put a comment into the Chat field regarding how you feel about the state of our current healthcare system and its functioning.. What would be YOUR “why”?



The background of the slide is a photograph of a mountain range at sunset or sunrise. The sky is filled with clouds, some of which are illuminated from below by the low sun, creating a warm, orange and yellow glow. The mountains in the foreground are dark and silhouetted against the lighter sky. The overall mood is contemplative and inspiring.

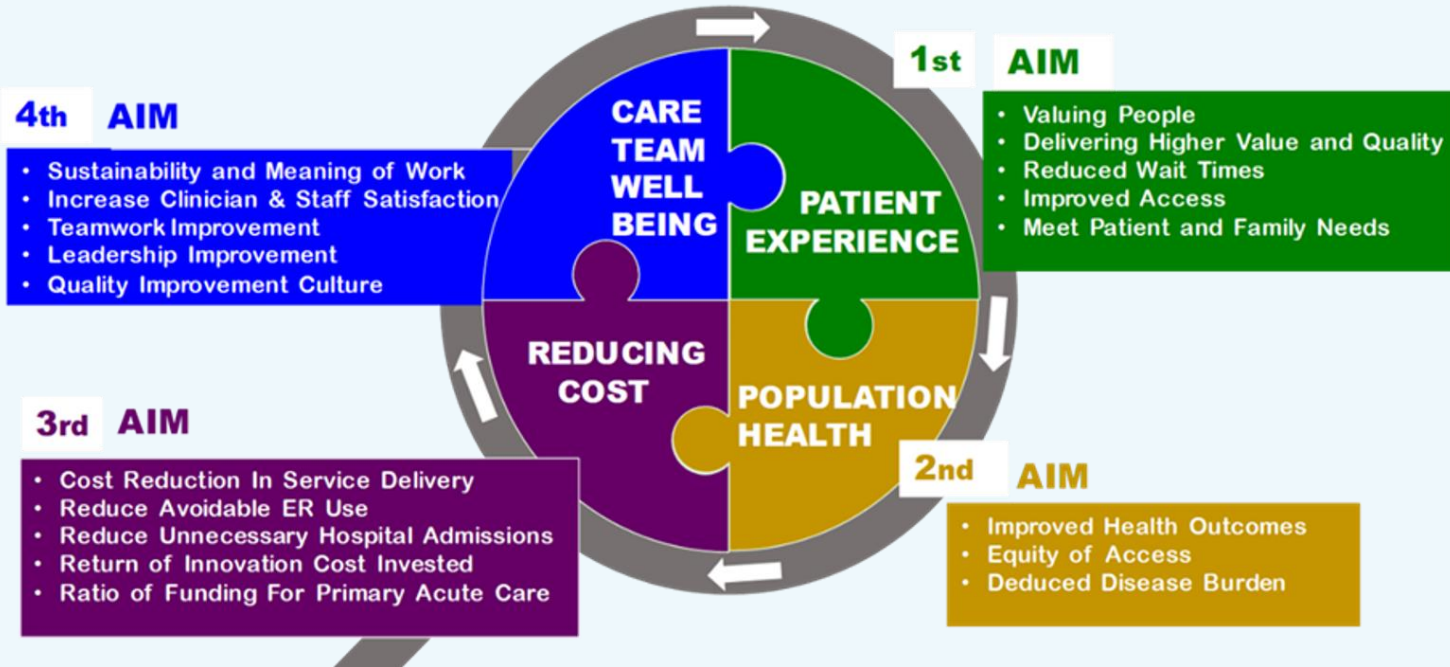
What got you here won't get you there.

Marshall Goldsmith



Getting from here to there...

The Quadruple Aim



IOM Quality Aims - Crossing the Quality Chasm



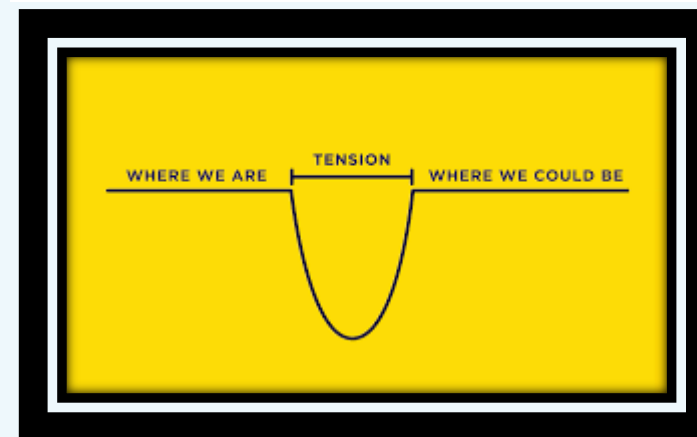
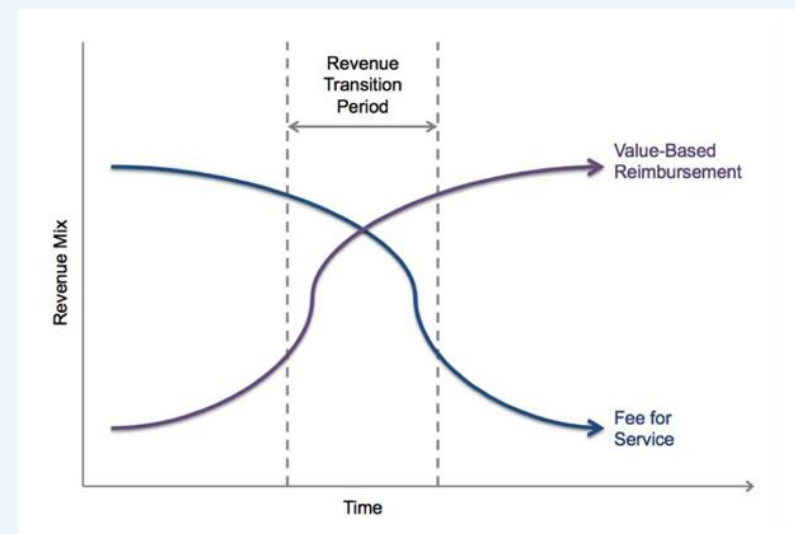
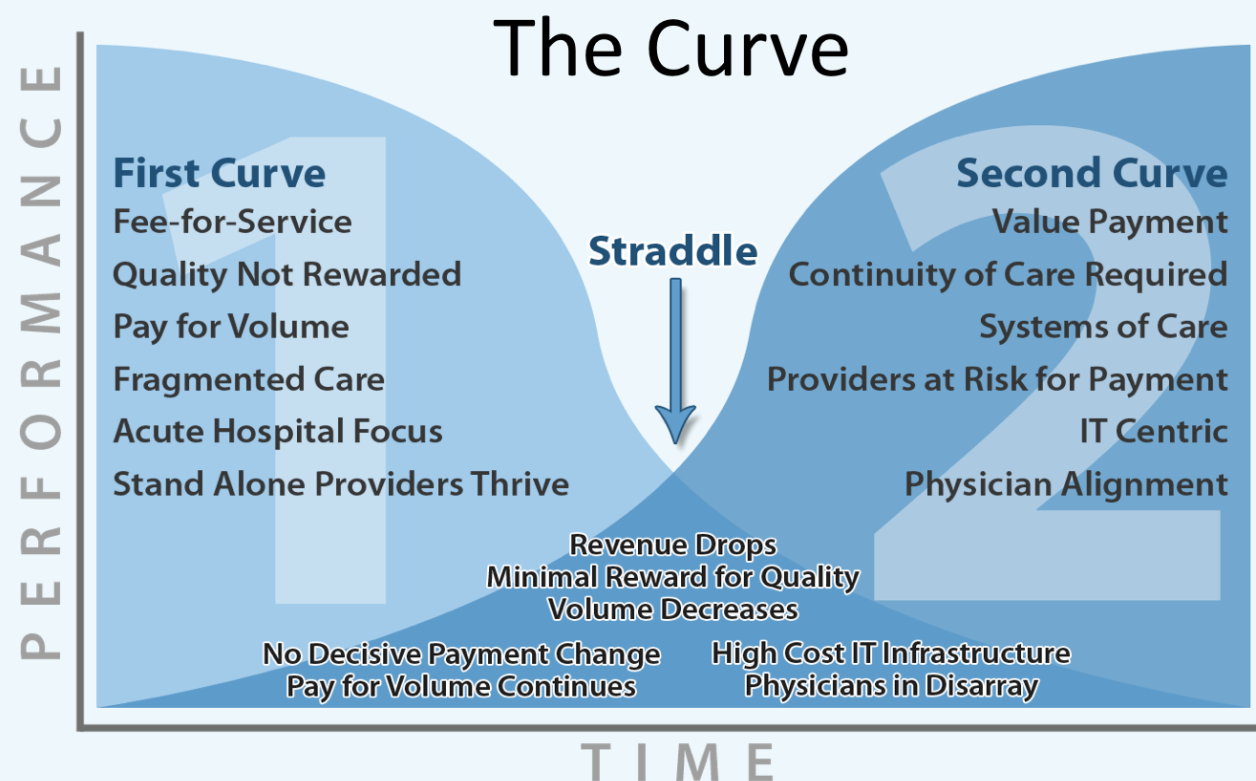
- IOM Quality Aims - STEEEP
 - **Safe** - no harm with care
 - **Timely** - avoid delays
 - **Effective** - match science to care-avoids overuse and underuse
 - **Efficient** - avoid waste- only provide value to patient
 - **Equitable** - every patient, regardless of background or vulnerability receives the best care
 - **Patient centered** - people in control of own care- *nothing about me without me*

The right care, in the right way, at the right time



Transitions are Underway

- Revenue Model



Continuum of Value-Based Care Risk and Transformation

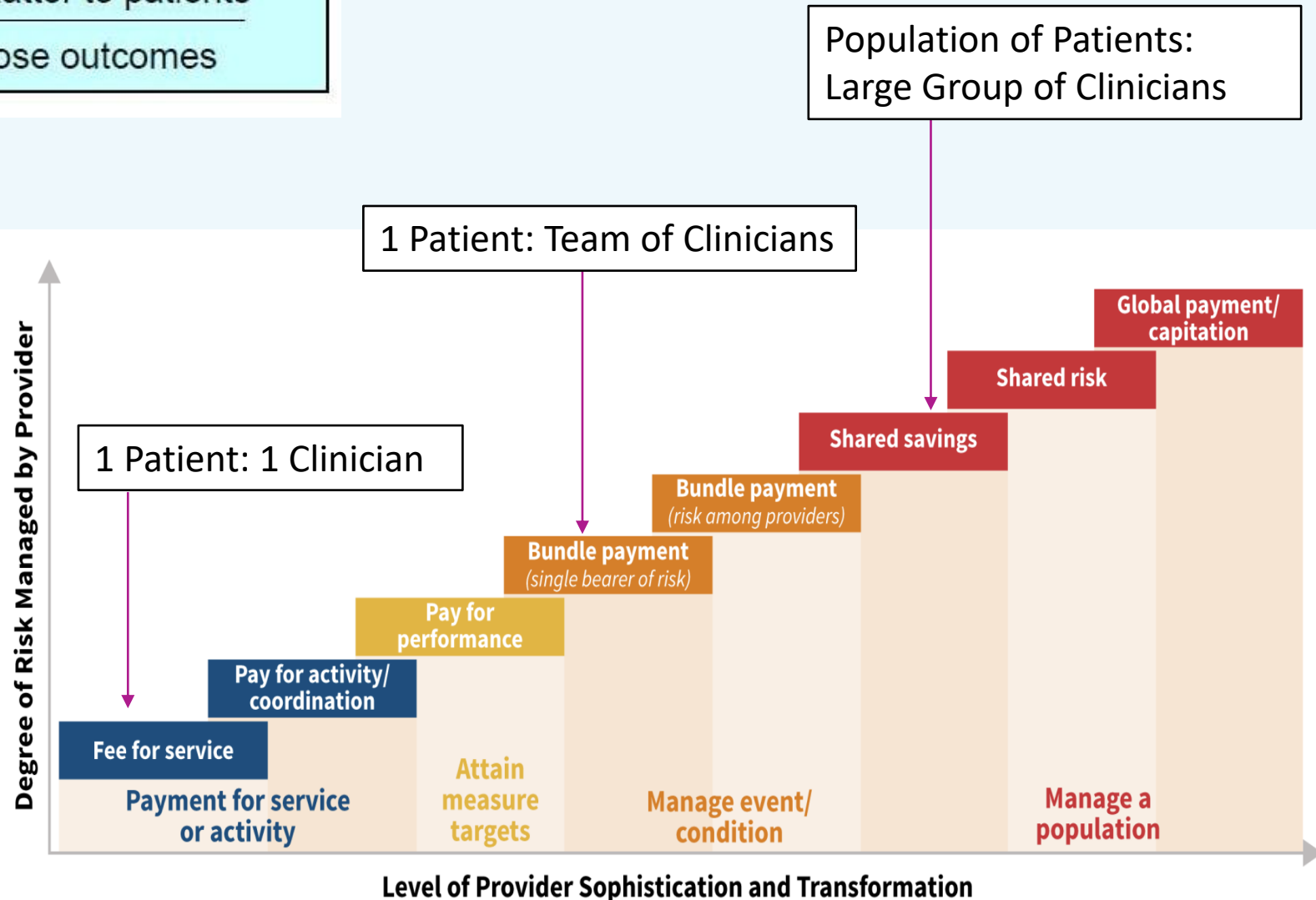
$$\text{Value} = \frac{\text{Health outcomes that matter to patients}}{\text{Costs of delivering those outcomes}}$$

$$\text{Revenue} = \text{FFS}$$



$$\text{Revenue} = \text{FFS} + V_{(\text{Value})}$$

Strong performance on Value-Based Contracts supports our favorable FFS rates



Value Based Care \$

- Different payment models
- Based on risk levels
- Category 1 through 4
 - Highest risk = 4
- Accountable care $\neq$ FFS
- Only when reimbursement is high enough, or mandatory programs are implemented, will VBC movement occur more rapidly
- Downside risk drives bigger results

Alternative Payment Models

THE APM FRAMEWORK

HCP LAN
Health Care Payment Learning & Action Network

This Framework represents payments from public and private payers to provider organizations (including payments between the payment and delivery arms of highly integrated health systems). It is designed to accommodate payments in multiple categories that are made by a single payer, as well as single provider organizations that receive payments in different categories—potentially from the same payer. Although payments will be classified in discrete categories, the Framework captures a continuum of clinical and financial risk for provider organizations.

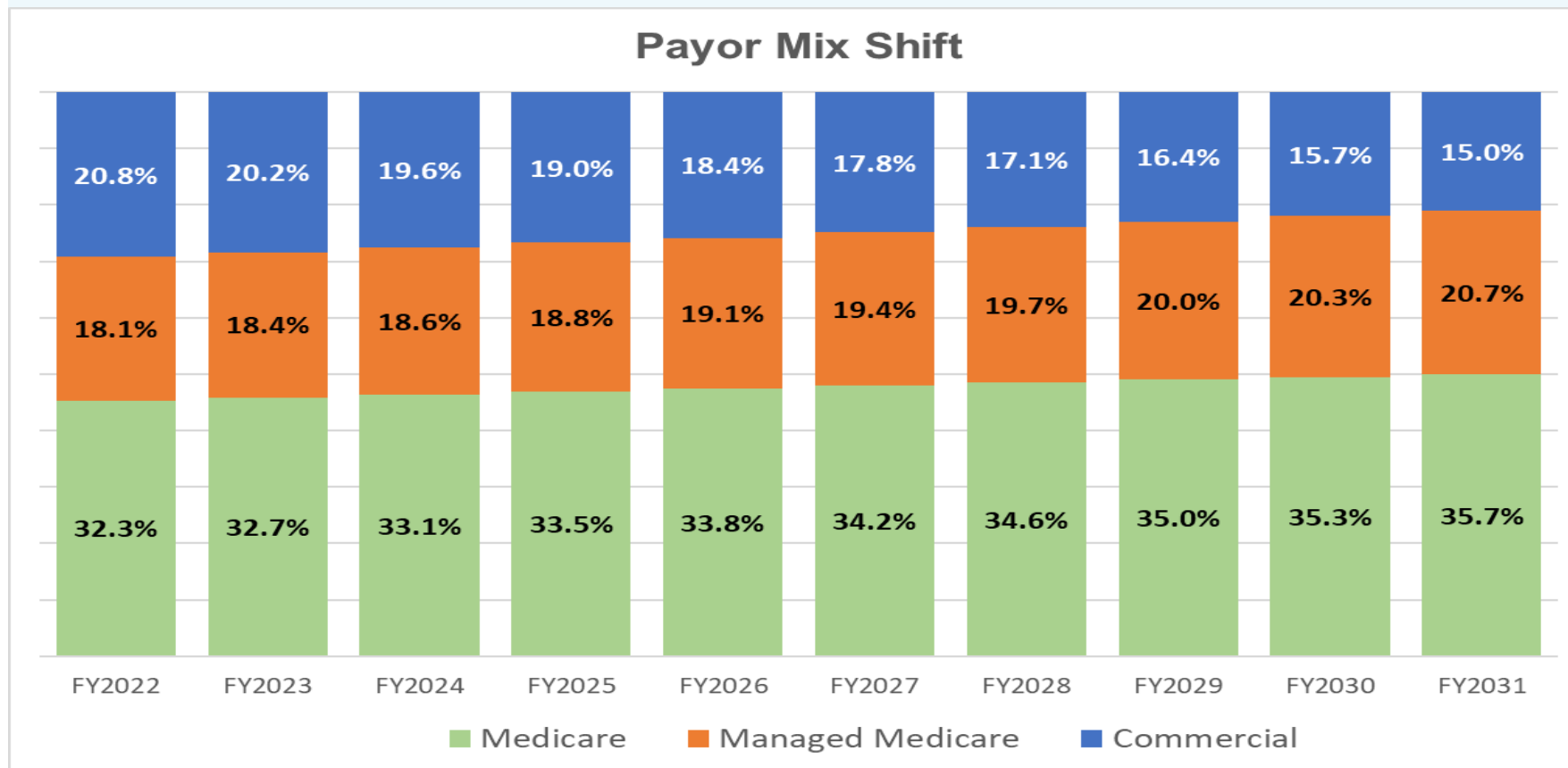
			
CATEGORY 1 FEE FOR SERVICE – NO LINK TO QUALITY & VALUE	CATEGORY 2 FEE FOR SERVICE – LINK TO QUALITY & VALUE	CATEGORY 3 APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE	CATEGORY 4 POPULATION – BASED PAYMENT
	A	A	A
	Foundational Payments for Infrastructure & Operations (e.g., care coordination team and payments fee)	APMs with Shared Savings (e.g., shared savings with upside risk only)	Condition-Specific Population-Based Payment (e.g., per member per month payment, accountable care)

	Medicaid	Commercial	Medicare Advantage	Traditional Medicare
2024	25%	25%	55%	50%
2025	30%	30%	65%	60%
2030	50%	50%	100%	100%

Note: The LAN will be seeking public comment on these goals.

Table 2. Categories 3B and 4 APM Goals by LOB

Anticipated Payor Mix Shift FY22 through FY31



- Government payers reimburse less than cost
- Commercial payers make up the difference

Academic Integrated Delivery Financial System



Vision Alignment

Mission

We Improve Lives.

Vision

Reimagining health, education and discovery to create unparalleled value.

Our Values

The behaviors our employees demonstrate daily to patients and their fellow staff enable Jefferson to continue to achieve its mission. Jefferson's values define who we are as an organization, what we stand for, and how we continue the work of helping others that began here nearly two centuries ago. These values are:



Put People First

Service-Minded, Respectful & Embraces Diversity



Be Bold & Think Differently

Innovative, Courageous & Solution-Oriented



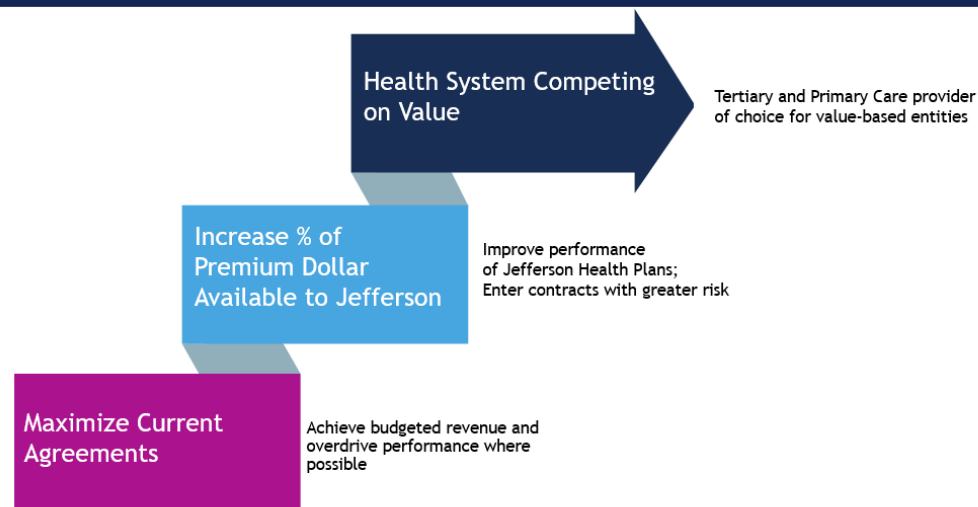
Do the Right Thing

Safety-Focused, Integrity & Accountability

Population Health Vision Statement

Guided by our mission to *Improve Lives* and our vision to *Reimagine health, education, and discovery to create unparalleled value*, Jefferson Health will lead a transformative approach to population health—**one that optimizes value-based care (VBC) performance, empowers a centralized and agile population health team, and influences systemic change to elevate the health and wellness of every community we serve.**

Population Health and Value Strategy

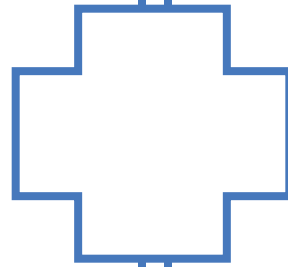


Jefferson Value-Based Care Landscape



2 Billion

Managed Premium
Dollars



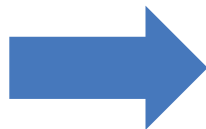
50+

Value Based
Arrangements



760,000

Lives in Value Based
Arrangements*



Lines of Business

Commercial (371K)

Medicaid (224K)

Medicare FFS/ACO (87K)

Medicare Advantage (78K)

3

MSSP ACOs

Confidential- Not for Distribution



Jefferson- LVHN Major Value Based and FFS PHO Contract Offering

\$180 Million in total combined VB contract earnings plus FFS messenger model rates on PHO contracts

LVHN PHO

- AmeriHealth Medicaid
- Cigna Commercial
- Capital Commercial & MA
- Highmark Commercial & MA
- MSSP ACO
- Jefferson Health Plans

JeffCare CIN

- IBX Commercial
- Cigna MA
- United MA
- Humana MA
- Aetna MA
- MSSP ACO

Jeff Care PHO

- Keystone First
- Cigna MA
- Geisinger MA
- UPMC MA

Einstein Care Partners CIN

- MSSP ACO
- JHP Medicaid & MA
- Aetna Commercial & MA
- Humana MA
- MSSP ACO

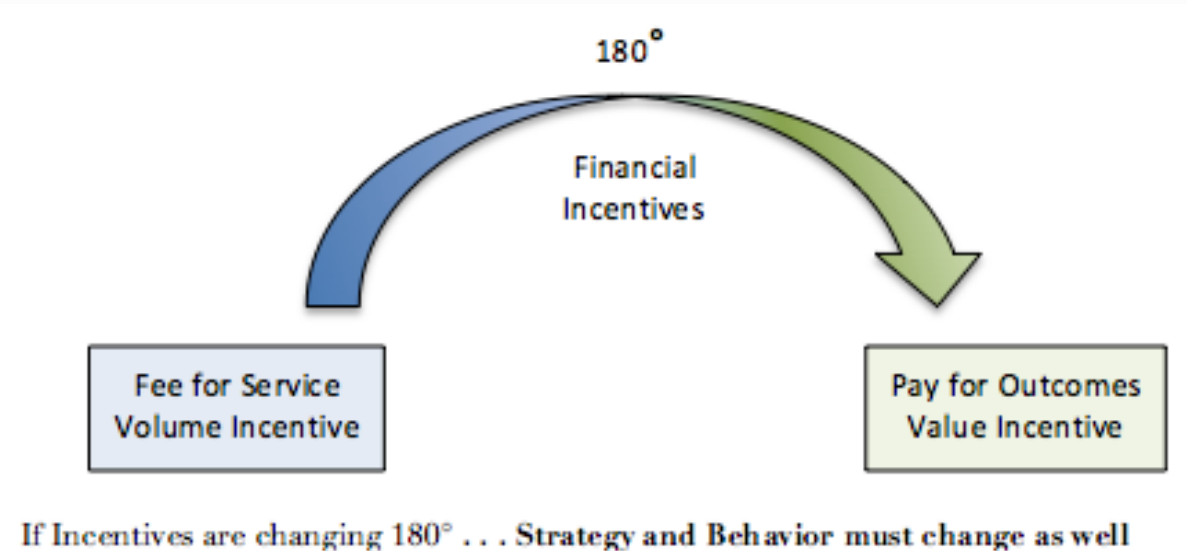
Population Health Services Support



Healthcare Improvement Strategy - Tactics in VBC

- Leadership / Organizational Strategy
- Attribution Management
- Risk / Coding Documentation
- Clinician Engagement
- Quality Performance
- Medical / Rx Spend
 - TOC / Continuity of Care
 - Care Pathways
- Care Navigation
- ***Data Analytics***

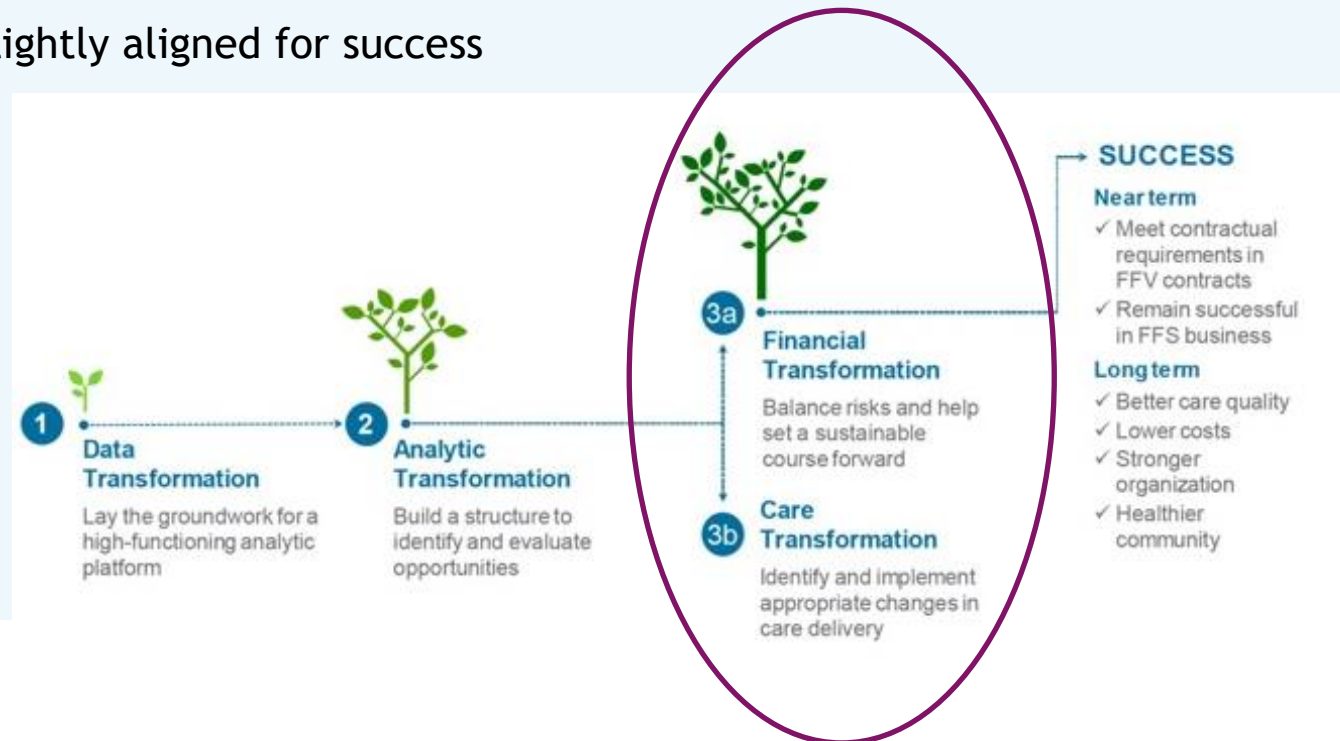
*Measuring is
key to
managing*



[Strategy-matrix-Health-Care.png \(527x222\) \(osipt.com\)](#)

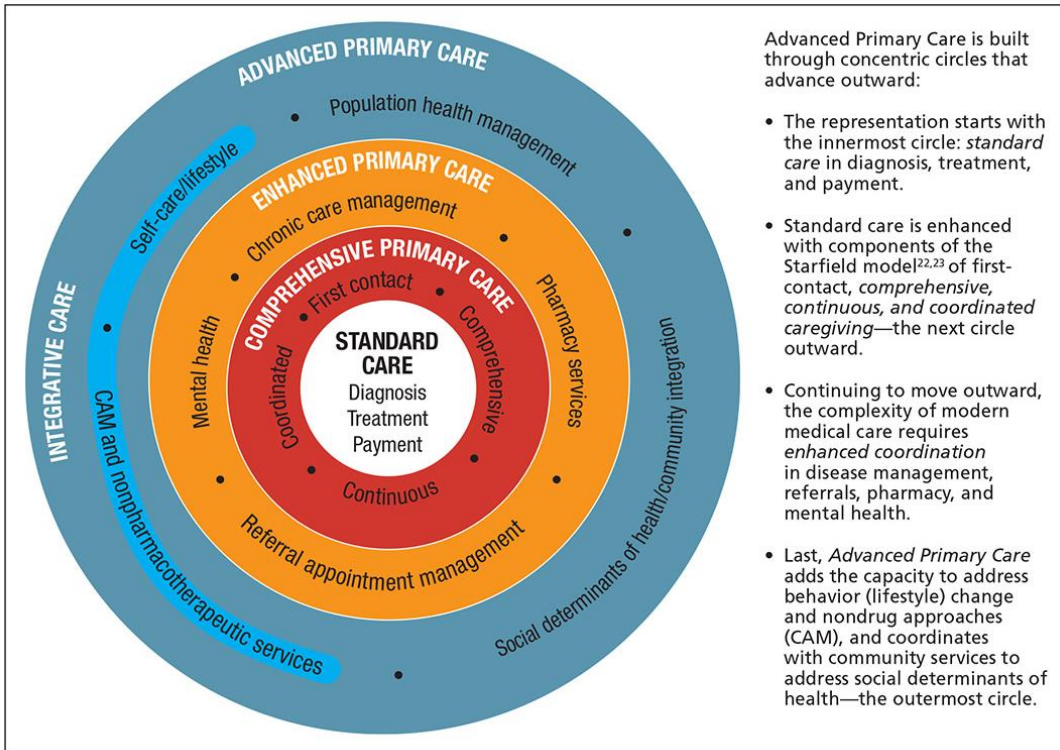
Jefferson Health

- Fee-For-Service organization
 - Clinical care delivery largely built around billable encounters
- Value Based Care focus - with demonstrated success
- Shared Savings in VBC requires decreasing patient utilization of services
 - Contracting and care transformation MUST be tightly aligned for success



Realizing our Vision – *Crucial Elements*

Advanced Primary Care

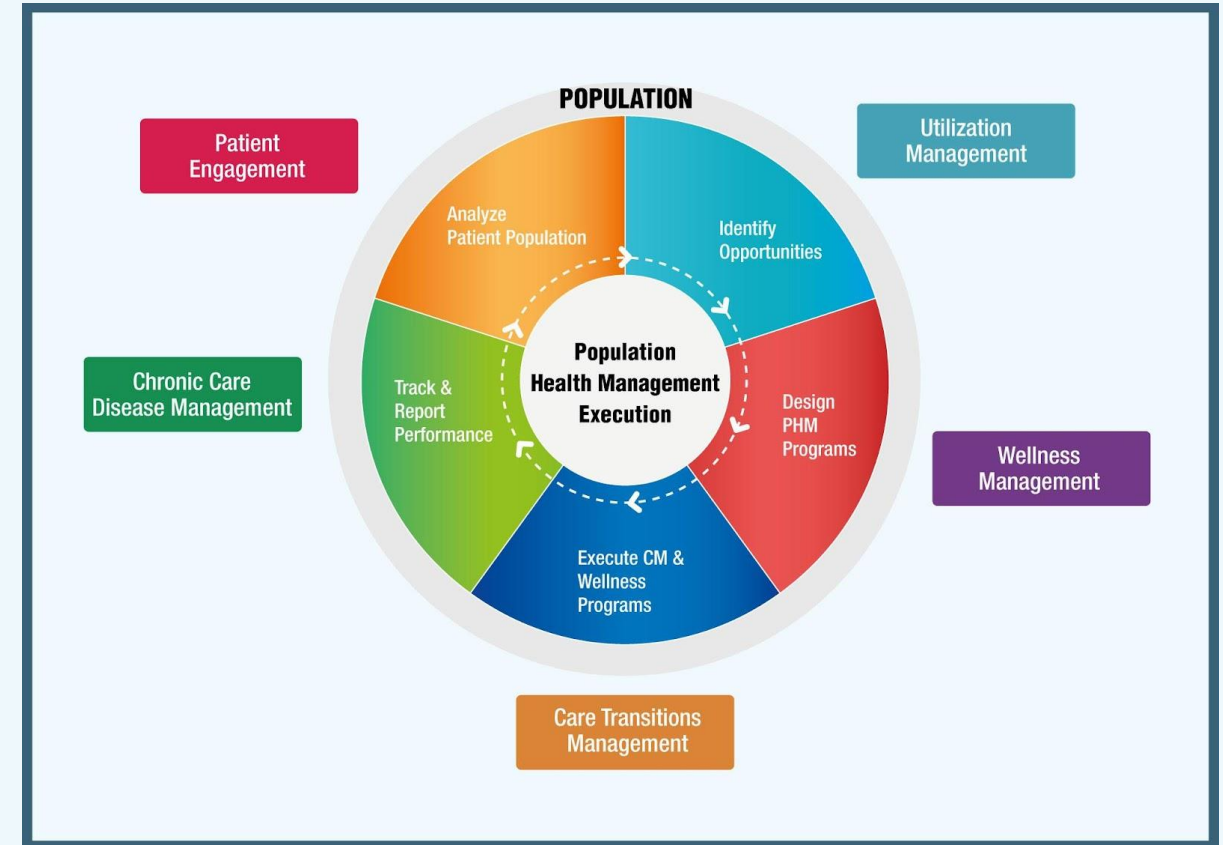


CAM, complementary and alternative medicine.

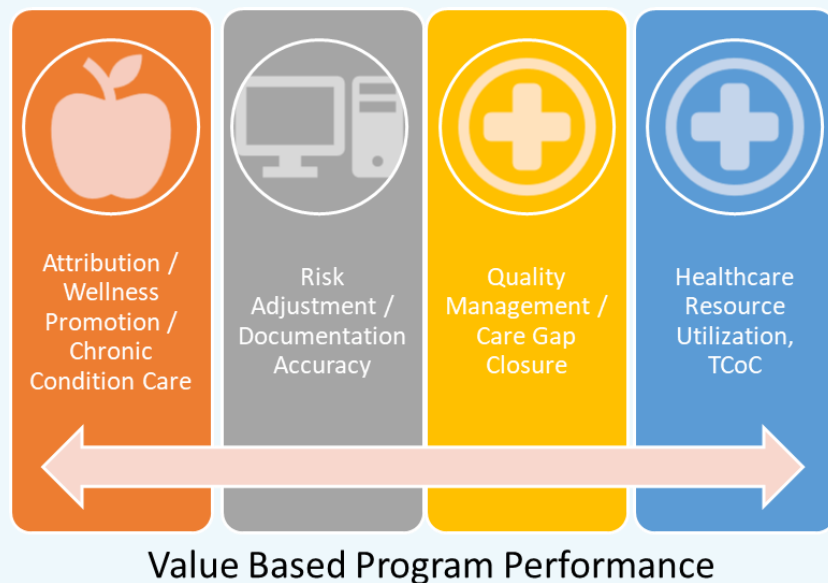
Advanced Primary Care is built through concentric circles that advance outward:

- The representation starts with the innermost circle: *standard care* in diagnosis, treatment, and payment.
- Standard care is enhanced with components of the Starfield model^{22,23} of first-contact, *comprehensive, continuous, and coordinated caregiving*—the next circle outward.
- Continuing to move outward, the complexity of modern medical care requires *enhanced coordination* in disease management, referrals, pharmacy, and mental health.
- Last, *Advanced Primary Care* adds the capacity to address behavior (lifestyle) change and nondrug approaches (CAM), and coordinates with community services to address social determinants of health—the outermost circle.

Population Health Management



Value-Based Care Delivery Transformation



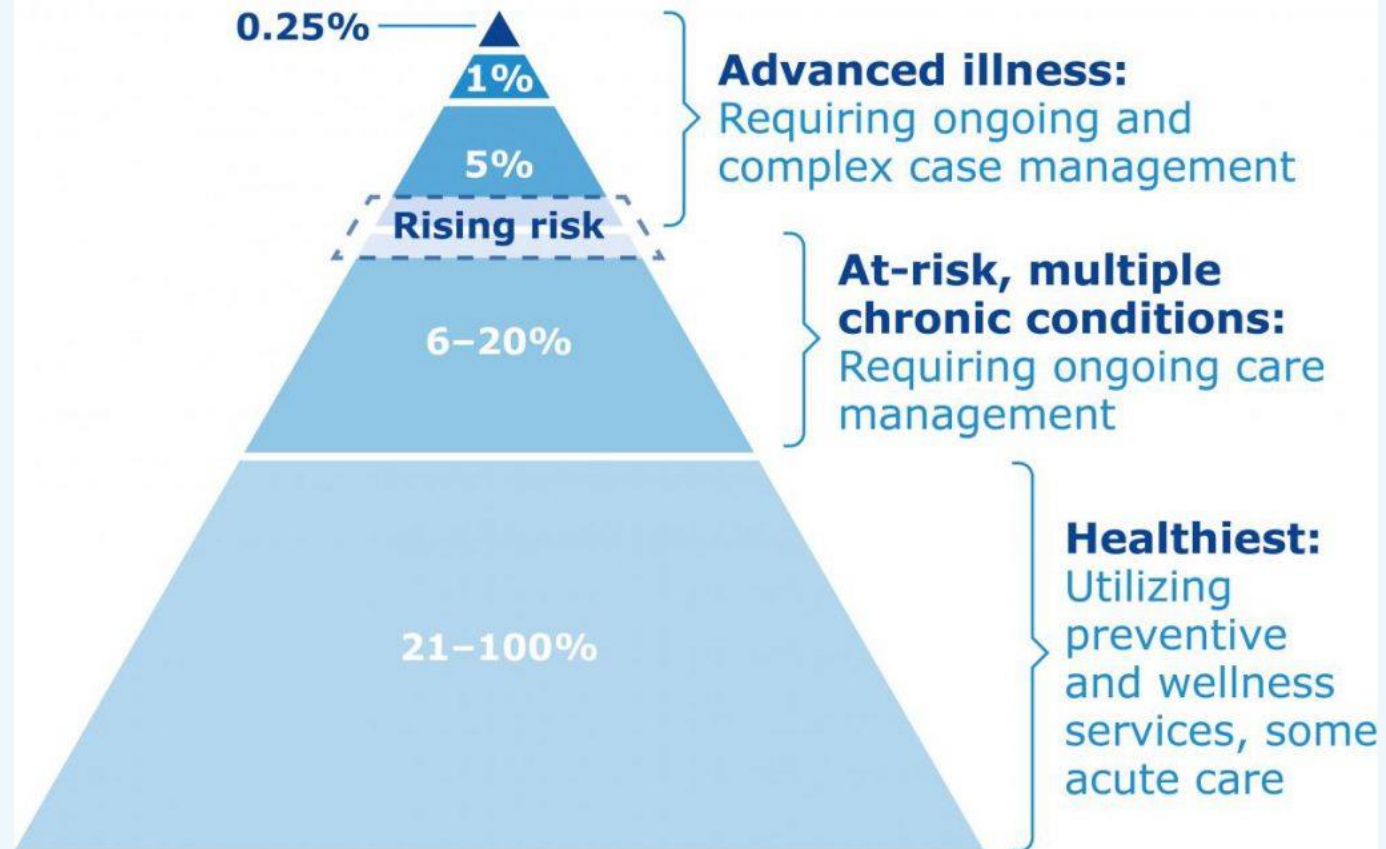
Population Health / Care Management



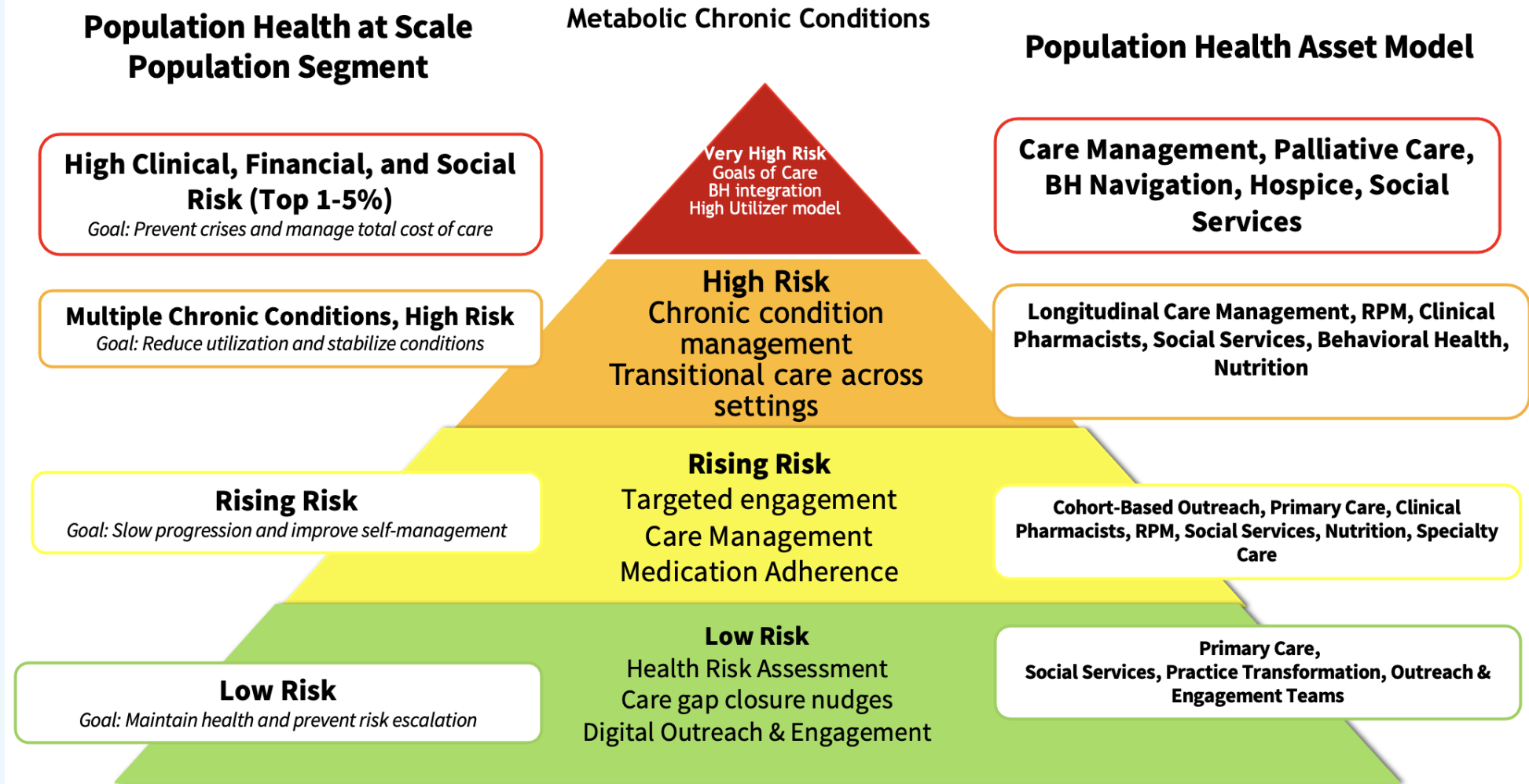
Interdisciplinary teams that span the continuum of care to coordinate services for our community.

Population Health Pyramid

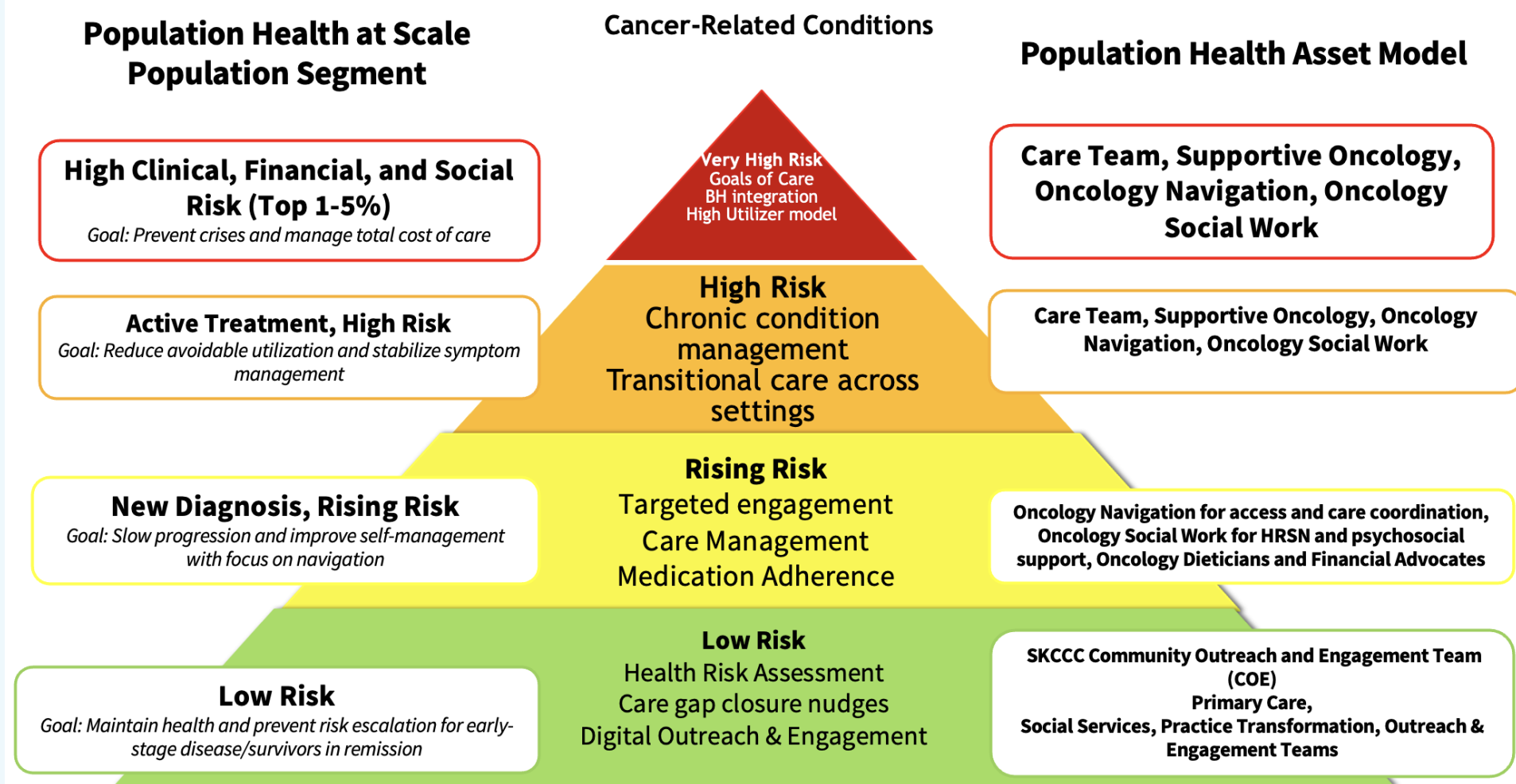
The top **5%** of patients account for **50%** of all medical costs.



Population Health Pyramid- Risk Tiering and Team-Based Care



Population Health Pyramid- Risk Tiering and Team-Based Care



Preventive Services / Screenings

- Initiatives:
 - Immunizations
 - Breast Cancer screening
 - Colon Cancer screening
 - Lung Cancer screening
 - BP screening
 - Bone Density screening
 - AAA screening
 - Depression screening
 - Pediatric Lead screening
 - Infectious disease screening (HIV, HCV, etc.)
- Wellness campaigns:
 - Centralized blast campaigns
 - Partnering with Payers
 - Practice-directed outreach
 - Mailing campaigns
 - EMR Portal messages, SMS messages
 - AI agentic outreach
- Social media / LVHN aligned
- Data / Analytics - direct / guide focused efforts
- Extensive performance tracking



Risk Adjustment Accuracy / Documentation & Coding Improvement

- Technology solutions
- RA Coding team
- Real time feedback Incentive linkage
- Extensive education



- ▶ Health plans are funded based on Risk Adjustment Factors
- ▶ Under coding leads to underpayment and loss of revenue
- ▶ Over coding leads to audit risk and compliance actions
- ▶ Example taken from AAPC:

HCC Financial Differences in Coding Specificity

No Conditions Coded (Demographics Only)		Some Conditions Coded (Claims Data Only)		All Conditions Coded (Chart Review by Certified Coder)	
76 year-old female	.468	76 year-old female	.468	76 year-old female	.468
Medicaid Eligible	.177	Medicaid Eligible	.177	Medicaid Eligible	.177
DM Not Coded		DM (no manifestations)	.118	DM with Vascular Manifestations	.368
Vascular Disease not coded		Vascular Disease without complication	.299	Vascular Disease with complication	.41
CHF not coded		CHF not coded		CHF coded	.368
No interaction		No interaction		+ Disease Interaction bonus RAF (DM + CHF)	.182
Patient Total RAF	.645	Patient Total RAF	1.062	Patient Total RAF	1.973
PMPM Payment for Care	\$452	PMPM Payment for Care	\$743	PMPM Payment for Care	\$1,381
Yearly Reserve for Care	\$ 5,418	Yearly Reserve for Care	\$8,921	Yearly Reserve for Care	\$16,573

DBC / HCC Engagement

Division	Practice	July 25	Dec 25	Change Since July
EPPI	Einstein Geriatrics at Bustleton Avenue	83%	98%	16%
ECHA	Einstein Primary Medicine at Elders Hall	94%	98%	3%
ECHA	Einstein Primary Medicine at Front and Olney	96%	97%	1%
EPM	Norristown Family Physicians	95%	97%	2%
ECHA	Einstein Primary Medicine at Center One	95%	96%	1%
EPM	Broad Axe Family Medicine	93%	96%	3%
EPPI	Einstein Geriatrics at Moss Building	89%	96%	7%
ECHA	Einstein Primary Medicine at Wayne Avenue	93%	96%	3%
EPM	Trappe Family Practice	91%	95%	4%
EPM	Plymouth Meeting Family Medicine	92%	95%	3%
EPM	Einstein Physicians Collegeville	85%	94%	9%
ECHA	Einstein Pediatrics at Township Line Road	84%	93%	9%
EPM	North Wales Family Medicine	90%	93%	3%
ECHA	Einstein Pediatrics at Holland	80%	92%	12%
EPM	Montgomery Family Practice (RC)	90%	92%	2%
EPM	King of Prussia Family Medicine Mall Blvd	88%	91%	3%
ECHA	Einstein Primary Medicine at Roxborough	84%	91%	7%
EPM	Einstein Physicians Norriton (RC)	85%	91%	5%
EPPI	Einstein Geriatrics at Klein 300 MSS	88%	90%	2%
EPPI	Einstein Geriatric Home Visits	86%	89%	3%
ECHA	Einstein Pediatrics at Center One	67%	89%	22%
ECHA	Einstein Primary Medicine at Klein Building	84%	89%	4%
ECHA	Einstein Primary Care at Logan Plaza (RC)	85%	88%	3%
ECHA	Einstein Primary Medicine at Mayfair	84%	87%	3%
ECHA	Einstein Pediatrics at Pennypack	84%	87%	3%
ECHA	Einstein Pediatrics at Frankford Avenue	66%	84%	18%
ECHA	Einstein Pediatric Adolescent & Ambulatory Center	73%	80%	7%
EPPI	CPC Immunodeficiency Clinic	60%	76%	17%
EPM	Trappe Pediatric Care	54%	76%	22%
EPPI	CPC Northern Medical Associates (RC)	50%	70%	19%

- Our Enterprise
- Employee Resources
- Clinical
- University
- JHP

- Population Health
- Overview
- Connectivity
- Education
- Resource Directory
- External Resources

Population Health

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Hierarchical Condition Categories (HCC) & Disease Burden Capture (DBC)

Overview

As Jefferson Health transitions from a fee-for-service model to Value-Based Care (VBC), we're entering a new era that prioritizes high-quality outcomes and patient-centered care. This shift not only benefits our patients and communities—it also fosters more collaborative, efficient and rewarding environments for clinicians.

Given that, success in VBC depends on one critical factor: accurate and meaningful clinical documentation.

While EHRs and AI tools can assist, it's your clinical expertise and attention to detail that ensure our documentation reflects the true complexity of our patients' health and the resources here can help – you'll find

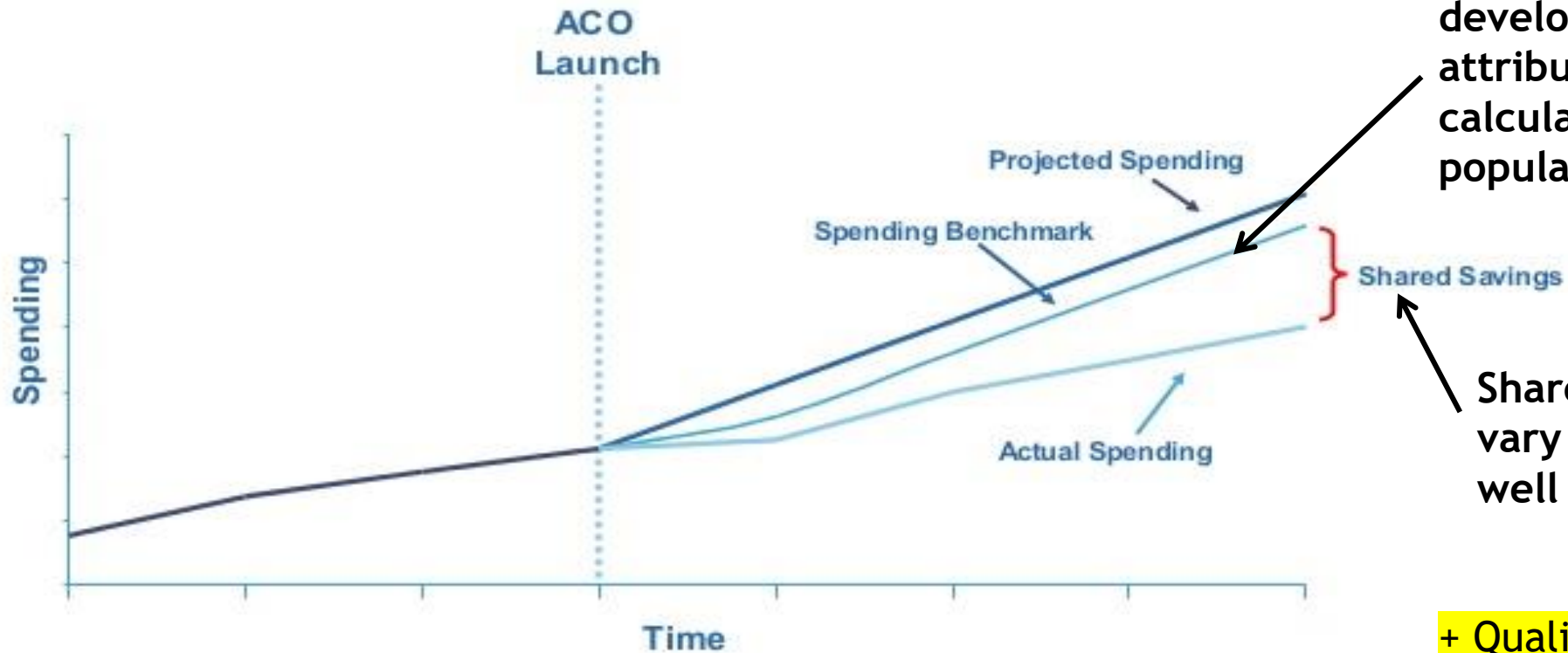
- Clear guidance on HCC code capture & documentation best practices
- Monographs, videos and quick-reference tools to support your workflow
- Direct access to expert coders and physician champions for peer-to-peer support
- Resources that make documentation easier and more intuitive

Impact of Disease Burden Capture & HCC Risk Adjustment on Value-Based Care

Accountable Care Reimbursement

How does the ACO “Shared Savings” Model Work?

Initial shared savings derived from spending below benchmarks



Spending Benchmark developed based on attribution size and calculated risk of the population

Shared Savings models vary with programs as well

+ Quality Metric performance

Teams Chat Comment

- *Do you think value is a better approach to healthcare payment - meaning, do you think it will be successful at changing the healthcare economics in our country?*
- *One sentence answer - brevity is ok 😊*

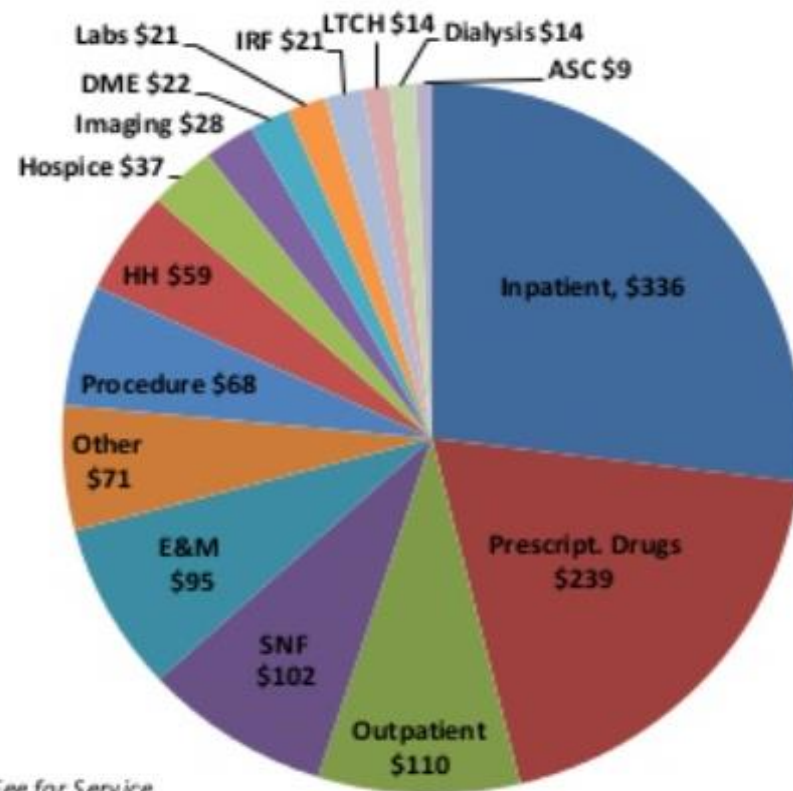


What Is Included in Total Cost of Care

Total Cost of Care includes the complete range of health care services

For Medicare patients, including beneficiary contribution, the average total cost of care is ~\$1,245 Per Beneficiary Per Month ("PBPM") for the following basket of services

How is ~\$1,245 PBPM Spent?



Figures include
~20% more
PBPM to
account for
patient
contribution

Definitions
SNF: Skilled
Nursing Facility
HH: Home
Health
DME: Durable
Medical
Equipment
LTCH: Long Term

E&M: Evaluation
and Mgmt.
ASC: Ambulatory
Surgery Center

Source: Data adjusted from 2011 Medicare Fee for Service.
Claims for illustrative purposes.

Multiple Levers Impact PMPM and Outcomes

Utilization Management	• Shadow UM processes with peer-to-peer review • EBM based conservative treatment requirements
Site of Service	• Outpatient surgical programs • Clinic-based infusions • Free-standing radiology or laboratories
Pharmacy	• Generic substitution • Step therapy • MTM / medication reduction & optimization
Clinical Variation	• EBC clinical pathway development and adherence. Clinical pathways must include the full spectrum of care (e.g. ambulatory, urgent care/ED, acute hospitalization, transitions, post-acute)
ED Management	• Enhanced primary care access (extended hours/weekends) • Urgent care site education & optimization • ED onsite care management & frequent utilizer management
Postacute Management	• Preferred partner SNF and HH networks • SNFist program • LOS management • Standardized discharge criteria
Primary Care service delivery	• Optimize primary care management of common conditions (e.g. diabetes, HTN) • Established referral criteria & expectations



Epic RX Cost Functionality - Example

Report Viewer

DEXILANT 30 MG CAPSULE, DELAYED RELEASE Pharmacy Coverage Summary

Coverage for currently selected plan: HIGHMARK/HD (ESI1)

Plan	Formulary	Copay	Coverage
HIGHMARK/HD (ESI1)	Not on Formulary	Cost-Based Alternatives	

Formulary Icon

- The medication appears to be on the formulary, but may have additional restrictions.
- The medication appears to be on the formulary, but may have some restrictions to determine if it is covered.
- The medication is not on the formulary.
- The formulary status of the medication is not known.

① Why Am I Seeing These Alternatives?

dexlansoprazole (DEXILANT) 30 mg capsule is not on the preferred formulary for the patient's insurance plan. Below are alternatives which are likely to be more affordable. Do not assume that every medication presented is a clinically appropriate alternative.

These alternatives were suggested by the patient's pharmacy benefit manager.

Patient Estimates

Coverage for currently selected plan: HIGHMARK/HD (ESI1)

Plan	Formulary	Copay
HIGHMARK/HD (ESI1)	Not on Formulary	N/A

Formulary Icon

Alternative

PANTOPRAZOLE 20 MG TABLET, DELAYED RELEASE	P
PANTOPRAZOLE 40 MG TABLET, DELAYED RELEASE	P
OMEPRazole 10 MG CAPSULE, DELAYED RELEASE	P
OMEPRazole 20 MG CAPSULE, DELAYED RELEASE	P
OMEPRazole 40 MG CAPSULE, DELAYED RELEASE	P

Preliminary Patient Estimate for [Patient Name]

Prescriptions using HIGHMARK/HD (ESI1)

- ☒ lisinopril (PRINIVIL) 5 MG tablet \$8
GIANT PHARMACY 6243 -..., 90 tablet, 90 days
- ☒ sitagliptin-metformin (JANUMET) 50-1,000 mg per... \$25
GIANT PHARMACY 6243 -..., 180 tablet, 90 days
- ☒ dexlansoprazole (DEXILANT) 30 mg capsule \$55
EXPRESS SCRIPTS HOME... , 90 each, 90 days
Prior Authorization required, Step Therapy required, Dr...

Payer-Suggested Alternatives

- ☐ PANTOPRAZOLE 40 MG tablet \$4
EXPRESS SCRIPTS HOM..., 90 each, 90 days \$0.05/day
- ☐ PANTOPRAZOLE 40 MG tablet \$3
GIANT PHARMACY 624..., 30 each, 30 days \$0.09/day
- ☐ OMEPRazole 10 MG capsule \$8
EXPRESS SCRIPTS HOM..., 90 each, 90 days \$0.09/day

JD

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Patient Value Story- Einstein Philly ED Decant Program

Patient Journey

63 Year Old Male

Patient: 63M c/o chronic abdominal pain and unintentional weight loss. **Diagnosis:** Metastatic Colon Cancer (liver, lung, kidney, and T12 involvement), Type 2 Diabetes, and RUQ Abdominal Pain.

Clinical Rationale: Recent ED workup confirmed stage IV malignancy. Acute obstructive or embolic concerns were ruled out. The primary clinical focus is transitioning from acute diagnostics to chronic symptom management and oncological care. Patient is safely managed at home with a multimodal pain regimen while awaiting specialist intervention.

ACAH Plan: Telehealth/Field Responder visit completed. Multi-disciplinary coordination secured an immediate/ same-day Oncology follow-up. Education provided on the safe use of oxycodone and constipation management. Patient counseled on diabetes monitoring and red-flag symptoms. CM and RN teams are mobilized to address social determinants, specifically financial and insurance barriers identified during screening.

Outcome: Pain is stable on current home regimen. A high-priority specialist pathway is established with Oncology and PCP to manage the new cancer diagnosis and chronic comorbidities. Ongoing RN follow-up to ensure care continuity, facilitate insurance support, and monitor for any acute clinical changes during this high-risk transition.



Operational Guiding Principles

**MAKE IT EASIER
TO DO THE RIGHT
THING AND MUCH
HARDER TO DO
THE WRONG THING**



Clinical Quality Metrics linked to
VBR Contracts

172 → 19

Simplify
Attribution

Comm Form: None

COVID-19 Vaccine: **Overdue for booster dose**

⚠ CKD is not listed on the problem list

Primary Cvg: Work Comp/Work...
Value Based Registry

Allergies (6)

Preferred Lab: HNL LAB MEDICINE



▼ Medications

Please use the sections below to find the correct medication therapy for the patient.

Lab Results

Component	Value	Date
HGBA1C	11.3 (H)	10/29/2022
GFRC	45 (L)	11/14/2020
NGFRC	47 (L)	02/12/2022
AGFRC	55 (L)	02/12/2022
RMCR	16.9	02/18/2022
LDLCALC	98	10/29/2022

The ASCVD Risk score (Arnett DK, et al., 2019) failed to calculate.

▼ METFORMIN

Preferred 1st line therapy.
If A1c >9% and symptomatic, consider metformin PLUS basal insulin for initial therapy.
GFR 45-60 ml/min: Initiate cautiously and monitor renal function every 3 to 6 months.
Monitor vitamin B12 serum concentrations every 2-3 years in particular those patients with peripheral neuropathy or anemia.

☐ metFORMIN XR (GLUCOPHAGE-XR) 500 MG 24 hr tablet - INITIAL TITRATION
R-0

☐ metFORMIN XR (GLUCOPHAGE-XR) 500 MG 24 hr tablet - MAINTENANCE DOSE
R-3

⚠ Depression monitoring due for patient, please document PHQ.

Last PHQ Score

	Value	Time	User
PHQ Total Score	0	10/15/2021 9:29 AM	Jennifer L Stephens, DO

[Go to PHQ9](#)

Acknowledge Reason



Chat feature discussion

- Do you see areas that can improve total cost of care or clinical outcomes for your patients?
- List some in the chat feature



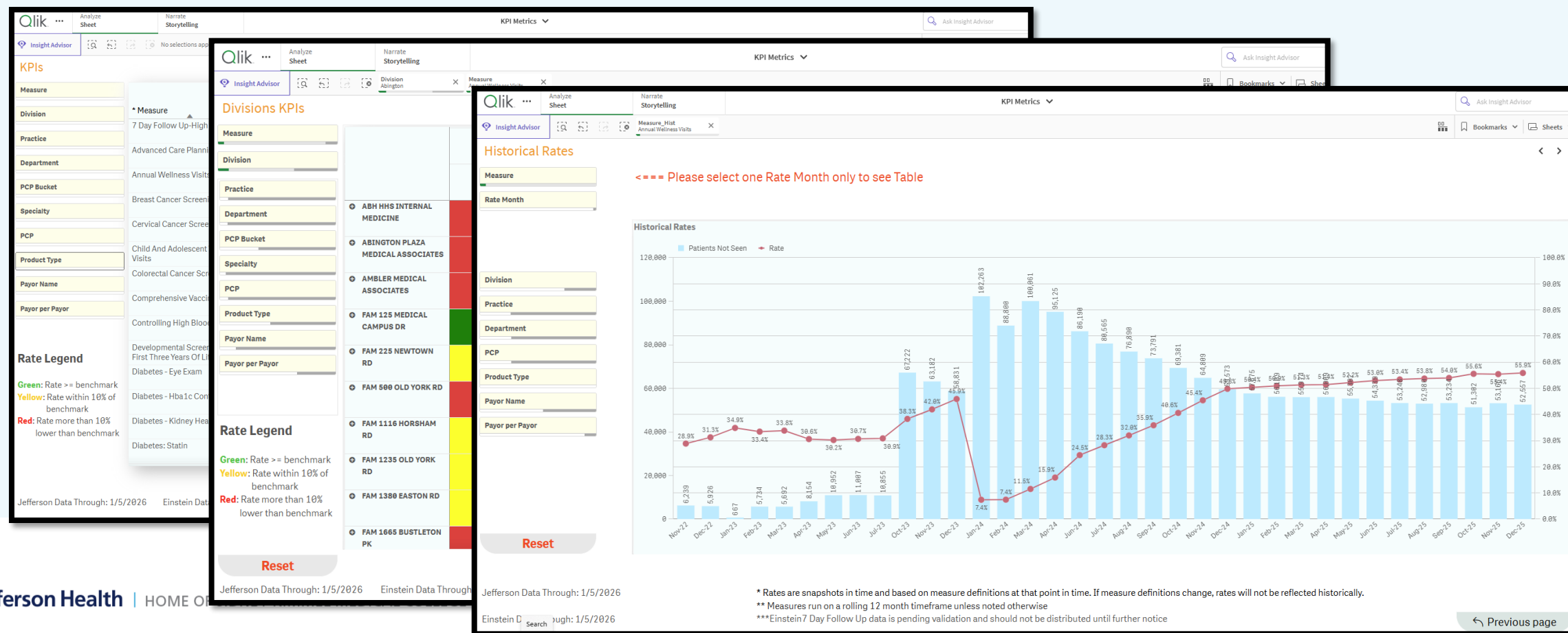
How Do We Manage Quality Performance?

- Leadership Role Clarity with Cascading Accountability
- Clinical Standardization - Care Pathways
 - Ambulatory and Inpatient pathway development / deployment / utilization
 - Team-based approach for success
- Integrate change into the EMR, real-time data
- Incentive models across clinicians and staff
- Robust data analytics, dashboard alignment, metric standardization

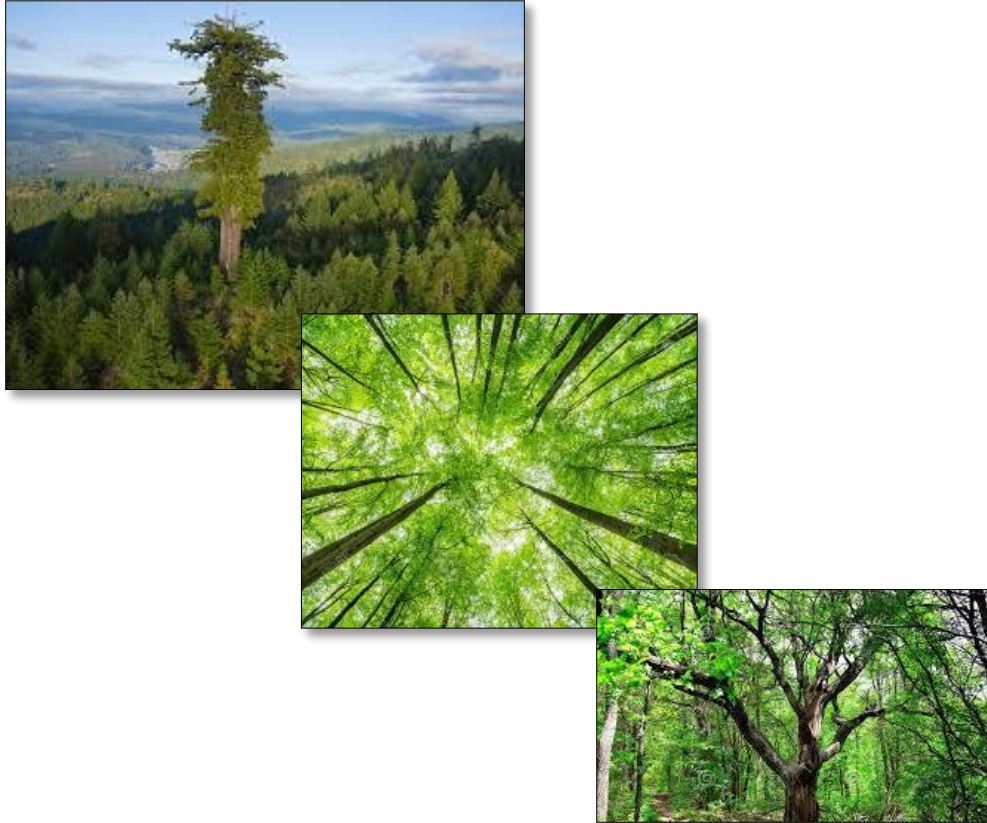


Quality Measures

- Manage your quality metric performance
 - As applicable to your specialty
- Team engagement, clinical coordinators and practice team alignment key for success



Measurement Data / Metrics – Feedback is CRUCIAL



- High to Low Lens
 - Executive, Practice, Individual
- Attribution Levels
 - All patients / all payers
 - VBC payers
 - Incentive program performance
- Filtering / Cohorting
 - Laser focus versus Pop Health
 - Value-directed, Central campaigns
 - DEI filtering

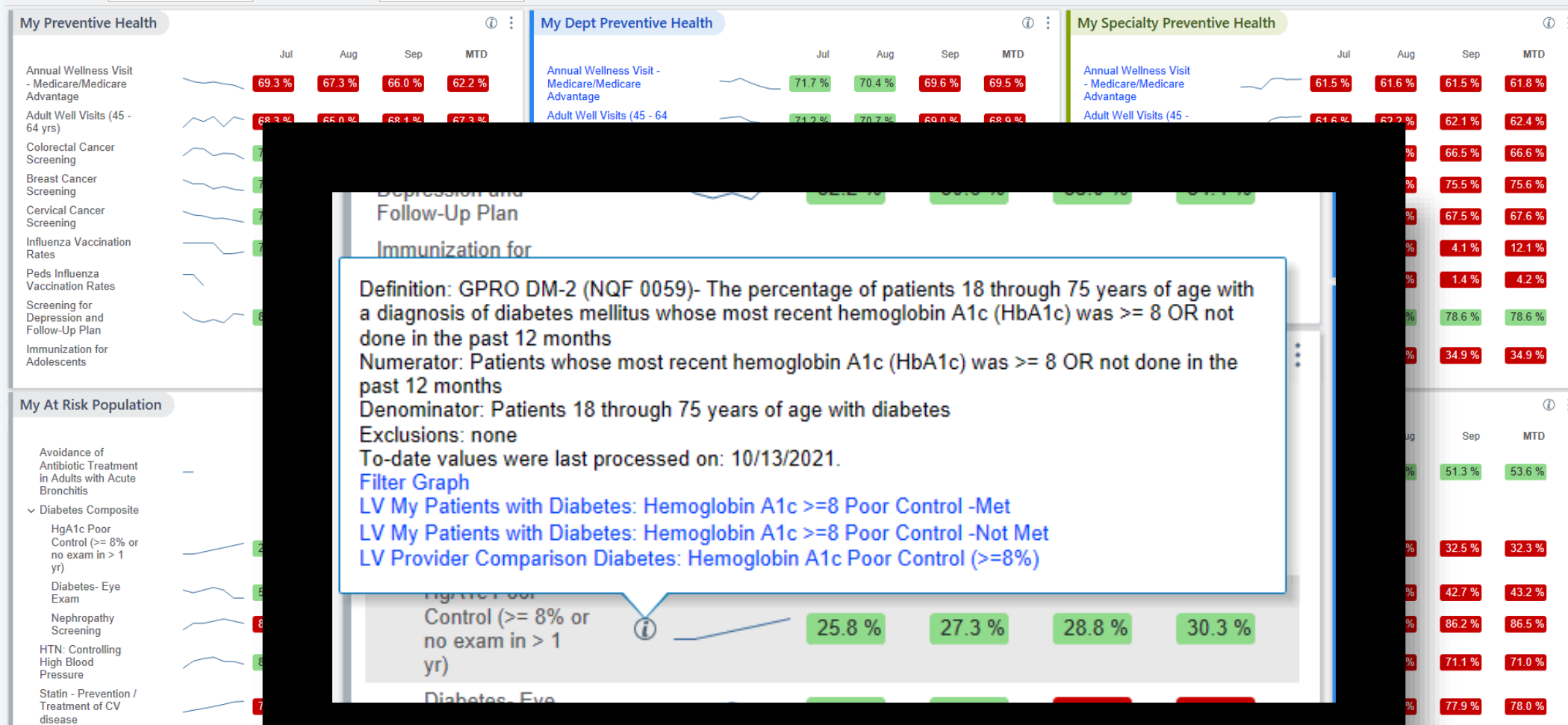
Non-Productivity Incentive Measures (Quality)

- Question - what does it take to engage clinicians and clinical care teams around quality and improvement work?

NAME
Abdominal Aortic Aneurysm (AAA) Screening
Breast Cancer Screening
Cervical Cancer Screening
Chronic Opioids: Pain Management Agreement
Chronic Opioids: Urine Drug Screen
Colonoscopy
Colorectal Cancer Screening
Diabetes: Eye Exam
Diabetes: Foot Exam
Diabetes: Hemoglobin A1C
Diabetes: Kidney health (eGFR)
Diabetes: Kidney health (urine microalbumin)
DTaP, Tdap and Td Vaccines
Hepatitis A Vaccines
Hepatitis B Screening
Hepatitis B Vaccines
Hepatitis C Screening
HIB Vaccines
HPV Vaccines
Influenza Vaccine
Lead Screening
Lung Cancer Screening
Lung Cancer Screening Eligible
Medicare Annual Wellness Visit
Meningococcal A Vaccine
Meningococcal B Vaccine
MMR Vaccines
Monkeypox Vaccine
Osteoporosis Screening
Pneumococcal immunization (0-49)
Pneumococcal immunization (50+)
Prostate Cancer Screening
Rotavirus Vaccines
Sigmoidoscopy/CT Virtual Colonoscopy
Statin Therapy
Varicella Vaccines
Zoster Vaccines



Leverage Epic Dashboards



Chat feature discussion

- Have you viewed your metrics / dashboard?
- If so, have you ever tried to close care gaps to improve your metrics?
 - Was it difficult?
- List some reflections in the chat feature

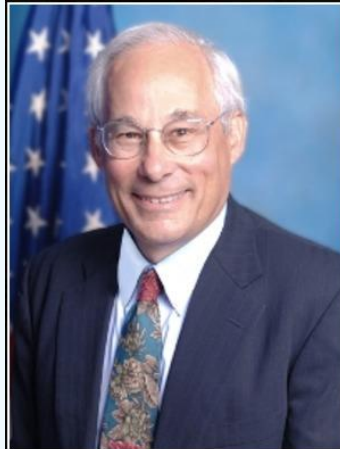
QI Model for Improvement

- IHI Modules
 - Review / concepts / brief discuss

Objectives

After completing this course, you will be able to:

1. Describe the need to integrate quality improvement and patient safety into health education training.
2. Discuss what the IHI Open School is and how it fits into IHI.
3. Explain tools and recommendations for building a vibrant IHI Open School Chapter.
4. Identify tactics that IHI Open School Chapters can use to maintain momentum.



Every system is perfectly designed
to get the results it gets.

— Donald Berwick —

AZ QUOTES

The screenshot shows the IHI Open School catalog interface. On the left, there are filters for 'Browse by' (Topic: Membership Courses, Open School), 'Filter by' (Format: Online (72), Blended (2)), 'User Ratings' (5 stars (2), 4 stars (72)), and 'Price Range' (Min Price: 0, Max Price: 1). Below these is a 'Topic' list including Open School (67), Open School Catalog English (36), Premium Plus Member Courses (14), Open School Basic Certificate Portuguese (14), Open School Basic Certificate English (13), Open School Basic Certificate Spanish (12), Premium Member Courses (10), Patient Safety Catalog (9), Free Sample Catalog (7), and MOC Part 2 Patient Safety (7). On the right, a search bar shows 'Your search returned 74 results'. Below the search bar, there are three course listings: 'L 201: The Role of Leaders in Workforce Safety' (5 stars, 77 reviews), 'TA 104: Building Skills for Anti-Racism Work: Supporting the Journey of Hearts, Minds, and Action' (5 stars, 14 reviews), and 'CPPS Review Course Webinar: February 17, 2022' (5 stars, 2 reviews). Each listing includes a brief description and an 'ENROLL' or 'ADD TO CART' button.

stEEP

- ▶ Safe,
- ▶ Timely,
- ▶ Effective,
- ▶ Efficient,
- ▶ Equitable
- ▶ Patient centered

Healthcare quality should be STEEP
Institute of Medicine report Crossing the
Quality Chasm



Quality Improvement Work

- Follow the IHI Model for Improvement
- Ensure you clearly know your AIM
- Go through every step of team formation, quality and change cycle (PDCA)
- Common pitfalls
 - Lacking detailed AIM
 - Solution jumping
 - Poor process mapping to identify key issues
 - Lacking appropriate metrics
 - Only doing one PDCA cycle
 - Not listening to feedback
 - Ignoring warning signs
 - Failure to engage senior leadership for resourcing / support



Quality Improvement Premortem



If 6 months from now we were to have found that this project failed spectacularly, what would be the most likely reasons?



Uncover blind spots and weak points before the project starts

Return on Investment

- Mission-Based Outcomes - *Patient outcomes, Population health improvement*
- Financial impact / value
 - True bottom-line value (FTE reductions, revenue generation, expense mitigation, service growth)
- VBR performance
 - Expense reduction
 - High cost, low value medications
 - Decreased resource utilization
 - Enhanced condition management
 - Improved care, driving less hospitalizations / ER visits
 - Care gap closure success
 - Attribution growth / improvement
 - Coding optimization - risk enhancement
- Clinician wellness / team engagement
 - Increasing patient satisfaction
 - Clinician wellness / engagement enhancement



Questions / Review

- Write down questions for discussion?
- What areas do you want to learn more about?
- What resources do you feel you need for success?



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