PTN TCPI Final Programmatic Progress Report

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Certification: I certify to the best of my knowledge and belief that this report is correct and complete for performance of activities for the purposes set forth in the award documents.

Name and Title of Awardee Project Director (Certifying Official):	Debra Simmons, Executive Director
Phone Number: ▪ Area code, Number, and Extension	Phone: (336) 716-1130
Email Address:	dwirth@wakehealth.edu
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TCPI PTN Final Performance Report

Section 1: Final Report

The CMS approved end date for the Transforming Clinical Practices Initiative (TCPI) was September 29, 2019.

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Section 2: Accomplishments and Lessons Learned

Table 1.0: COSEHC Progress Toward Aims by PTN Close Out

AIMs	Commitments as Stated in TCPi Award Document	Total Commitment Achieved Sep 29, 2015 – Sep 28, 2019
1. Support more than 140,000 clinicians in work to achieve practice transformation.	Actively engage 4,040 clinicians.	Engaged 4,692 clinicians (116% of commitment).
2, Improve health outcomes for 5 million of Medicare, Medicaid and CHIP beneficiaries and other patients.	Improve health outcomes for 73,465 patients with cardiovascular-related conditions.	Improved high-impact measures in 196,585 with cardiovascular-related conditions (268% of commitment).
3. Generate $1 to $4 billion in savings to the federal government and commercial payers.	Generate $59,589,852 in cost savings to federal government and commercial payers.	Achieved $192,592,276 in total cost savings (199% of commitment), for the total population comprised of 27% Medicare, 13% Medicaid, and 50% Commercial
4. Reduce unnecessary hospitalizations for 5 million patients.	Reduce 10,040 unnecessary hospitalizations as measured by the volume of ED visits, hospital admissions, and readmissions.	Avoided 43,130 all-cause hospitalizations, readmissions, and ED visits, representing 272% progress towards the commitment.
5. Sustain efficient care delivery by reducing unnecessary testing and procedures.	Reduce 10,916 unnecessary tests as measured through the Use of Imaging Studies for Low Back Pain.	Reduced 13,234 unnecessary low back pain imaging cases (121% of commitment).
6. Preparing 75% of practices completing the program to participate in Alternative Payment Models.	Transition 560 practice sites, representing 75% of total enrolled practices, to Alternative Payment Models before September 30, 2019.	Graduated 583 practice sites to Alternative Payment Models before September 30, 2019 (104% of commitment). • MSSP's = 84% • NGACO's = 12% • Medicaid ACO = 3% • CPC+ = 1%
7. Build the evidence base on practice transformation	Identify and submit 643 Exemplary, Early Exemplary, and	Submitted 650 total practices (101% of commitment) to the CMS Registry across the following categories:

so that effective solutions can be scaled.	Improvement practices to the CMS Registry before September 30, 2019.	• *Exemplary*: 456 practices • *Early Exemplary:* 83 practices • *Improvement:* 111 practices

Introduction

Over the past four years of the TCPi demonstration, the COSEHC QualityImpact PTN facilitated practice transformation for 4,692 clinicians providing care to over 2.1 million patients across the Southeast. As highlighted in Table 1.0, the PTN exceeded all goals across aims by providing patient-centered care solutions and executing customized action plans to meet the individual needs of each practice within the network. Of the 735 practice sites, CMS acknowledged 650 practices for their exceptional performance, 456 of which were recognized for their Exemplary patient outcomes and experience. In addition, 79 percent of enrolled practices transitioned to alternative payment models (APMs), having established the infrastructure and capabilities needed to succeed under value-based care arrangements. Detailed below, QualityImpact designed, refined, and implemented a number of strategies to maximize care outcomes and promote practice transformation.

Discussion of Project Activities

From enrollment to graduation, the QualityImpact PTN supported the clinical transformation of the practices by helping them build an infrastructure for sustained improvement through a number of key strategies including, but not limited to:

- Onboarding and recruitment
- Customizing action plans
- Engaging advisors
- Sharing best practices and facilitating peer-to-peer learning
- Accelerating quality improvement initiatives
- Leveraging data to improve care delivery
- Sustaining results

Recruitment and Practice Onboarding

QualityImpact's systematic recruitment and onboarding process prioritized gaining provider and care team buy-in. The PTN experienced widespread success as a result of level-setting on TCPi and network-wide goals and expectations, embracing shared priorities, and building trusting relationships. These key elements enabled the PTN to build a strong foundation for continued practice and provider engagement. The QualityImpact clinical and transformation advisory boards were essential to the success of the onboarding process due to their extensive clinical experience and ability to speak as peers to incoming clinicians. The practice facilitators were then able to triage practice concerns and align them with the appropriate PTN resources and advisory members.

Early on in the onboarding process, the PTN encouraged practices to identify clinical, technical, and transformational champions, who were responsible for ensuring the continued success of quality improvement activities and monitoring performance measures and progress toward aims.

These champions were critical in maintaining provider and care team buy-in and serving as the liaisons to the QualityImpact PTN technical support team.

QualityImpact's comprehensive practice onboarding package included a number of templated resources, ensuring a systemic approach while allowing the PTN to tailor the message to the individual practices' needs. Some key materials within the onboarding package included: an introductory brochure, a presentation identifying priority areas and a timeline for continued collaboration, technical assistance resources, a FAQs sheet for administrators and providers, an Enrollment Letter and Business Associate Agreement confirming participation, an onboarding presentation providing an overview of the PTN practice engagement, workflow and timeline materials, and a template for announcing practices' involvement in TCPi.

Engaging Key Advisors

Recognizing the critical importance of organizational buy-in, QualityImpact engaged a broad array of advisors to help facilitate the transition to value, including front line providers and care teams, administrators, IT staff, analytics specialists, payers, SANs, QIOs, and other PTNs.

To accelerate the transition to value and align incentives across the care continuum, the PTN established diverse breakout groups focusing on priority areas including the Care Management Working Group, Behavioral Health & Substance Use Disorder Subcommittee, Payer Advisory Group, and various Clinical Subcommittees. These groups provided key expertise on common challenges facing QualityImpact practices and helped guide initiatives to promote the transition to value.

In an effort to facilitate network-wide learning, the practices were divided into cohorts based on common gaps in clinical measures, practice size, and geographical locations using learning and action network (LAN) focused virtual and onsite sessions to problem solve, share best practices, and determine strategic processes to mitigate gaps using peer-to-peer sharing and subject matter expert (SME) led discussions. Through these expert-driven networks, the PTN developed numerous subcommittees, advisory boards, and peer-based working groups as highlighted in the examples below:

Example	Advisor Participants	Areas of Focus
Transformation Advisory Board	• ACO Directors • CMS Advisors	➢ Value-based readiness ➢ APM identification & alignment
Behavioral Health & Substance Use Disorder Subcommittee	• Guideline Experts • Health System Leaders • Pain Management Specialists	➢ Mental & behavioral health integration ➢ Opioid use reduction
Clinical Subcommittees ○ Pediatric ○ Cardiovascular ○ Respiratory ○ Gastroenterology	• Specialty Transformation Coaches • Medical Directors • Physician Experts	➢ Best practice care processes ➢ Evidence-based guidelines ➢ Population health management strategies

The QualityImpact PTN also engaged many key support alignment networks (SANs) and quality improvement organizations (QIOs) to gain additional insights into PTN priority areas, adopt

learnings, and scale best practices across the network. For example, to accelerate improvements in cardiovascular care across the network, the PTN partnered with the American Medical Associations (AMA) to promote the use of the AMA's Steps Forward modules and educational framework. The PTN hosted webinars featuring key modules from Steps Forward for the network. Additionally, the QualityImpact PTN collaborated with the American Psychiatric Association and the American College of Physicians to pilot programs within target practices, such as the Collaborative Care Model and Referral Workshops.

The PTN also collaborated with QIOs to on joint educational offerings, such as partnering with the Alliant Health Solutions to host a MIPS Consultation Desk at the 2019 Annual Learning Collaborative. The PTN also worked with QIOs to leverage instrumental resources for practices, including MIPS educational packages and performance assessment tools.

In addition, the QualityImpact PTN regularly engaged the TCPi community, actively participating and presenting in monthly QIN-QIO Collaboration Meetings, TCPi Pacing Events, and TCPi meetings, including the 2016 to 2019 CMS Quality Conference, 2018 National Expert Panel (NEP), and 2019 TCPi Exposition. The PTN leveraged these opportunities to both give back to the greater TCPi community by sharing findings and lessons learned and grow by adopting learnings from other high performing PTNs.

Customized Action Plans

The QualityImpact PTN took a personalized approach to practice transformation, allowing the PTN to address the individual needs of each practice within the network. Every engagement started with conducting an in-depth assessment using the Practice Assessment Tool (PAT). Based on these results, the practice facilitators (Quality Improvement Advisors) identified both practical, easily attainable areas for improvement, as well as critical capabilities that were aligned with the practice's goals and would be instrumental in preparing for value-based care. To execute on these initiatives, the facilitators and the practices co-developed customized action plans and employed strategies and resources appropriate for each practice's culture, archetype, and performance improvement needs.

Over the course of the TCPi demonstration, QualityImpact demonstrated its commitment to building lasting relationships centered around value transformation by individually engaging each enrolled practice through on-site visits. These on-site visits allowed the PTN to engage the entire practice team, review practices' current progress toward aims, align on future steps for sustained improvement, address emerging challenges, and identify opportunities for continued engagement. By building a relationship of trust and accountability across the PTN, 98 percent of enrolled clinicians were retained.

QualityImpact's successful approach can be demonstrated by the 79 percent of practices that transitioned to APMs by the end of the demonstration. In addition, QualityImpact PTN advisors, including Dr. Terry McGeeney (Care Delivery and Transformation Advisor), Jennifer Martin (Quality Consultant and NCQA PCMH Certified Expert), and Dr. David Hanekom (TCPi National Faculty and ACO Expert Advisor), provided one-on-one advising through individual practice calls, providing a customized approach to value transformation. QualityImpact involved a host of other Clinical Subject Matter Expert Advisors to facilitate clinical transformation

through various live education sessions and webinar series, such as the APM Readiness Bootcamp series, which featured three webinars covering topics including:

1. Common barriers to value transition, key elements of preparedness and best practices
2. Risk-based coding (HCC), scoring and documentation
3. Lessons learned from one practice's journey in creating their Next Generation ACO, focusing on risk stratification and care management

In addition, QualityImpact Advisors educated practices on APM availability in their markets through APM Landscape Mapping and offered consultative guidance pertinent to risk model readiness.

Learning Collaboratives

The QualityImpact PTN developed an extensive knowledge base of industry best practices and scalable solutions by facilitating peer-to-peer learning and sharing of best practices through the live Annual Learning Collaborative meetings, which featured over 150 quality improvement leaders, providers, and healthcare professionals from 53 organizations across the Southeast. Collaboratives focused on a number of TCPi related aims.

PTN leaders met to discuss lessons learned from the field and strategies to promote critical new evidence-based guidelines or innovations, accelerating the scaling of best practices across the provider community. As one of the overarching PTN goals, attendees were strongly encouraged to take lessons learned from the Annual Learning Collaborative and apply them within their clinical operations and overarching strategic plan. For example, by the end of the 2019 Annual Learning Collaborative, attendees developed actionable plans across numerous areas of focus, including:

- Engaging clinical teams in care models
- Managing hypertension and lipids
- Implementing care management, chronic care management, and more
- Standardizing screening and treatment for OUD and behavioral health
- Compliant coding and billing
- Reducing clinician burnout
- Integrating evidence-based clinical guidelines

Each year, QualityImpact recognized the highest performing practices for their commitment to improving patient care outcomes and advancing TCPi aims, ultimately driving results through friendly competition.

Accelerating Quality Improvement

Under TCPi, QualityImpact has provided practices the support they need via a population health management platform, data transparency, clinical education and coaching, and technical assistance to build an infrastructure for sustained quality improvement results.

In May 2017, the Performance Improvement Sprint initiative was launched to accelerate and sustain practice engagement in transformation activities targeting improved care quality, reduced cost, and better care experience. Practices completed a 12-month goal setting and implementation plan and were evaluated according to their resulting performance across cost and/or up to six quality measure categories: Ischemic Vascular Disease, Hypertension, Chronic Heart Failure, Adult Diabetes, Chronic Obstructive Pulmonary Disease, and Preventive Health. Cost performance was measured in terms of reductions in unnecessary emergency service utilization, specifically Avoidable Admissions, Avoidable ED Visits, and Readmissions. Practices were evaluated according to their improvements from baseline and asked to provide context around the successes, challenges, and lessons learned.

> As of Q3 in 2019, the PTN-wide hypertension control rates (BP 140<90 mmHg) improved **15 percent** from baseline across 524,221 patients, and diabetes care (HbA1c < 8) improved **5 percent** from baseline across 103,486 diagnosed Diabetes patients. While the PTN has shown steady improvement in quality and cost containment measures, this progress was notably accelerated by two quality innovation sprints: the 2017 Performance Improvement Sprint and 2018 Clinical Action Program (CAP).

Building on the success of the Sprint initiative, CAP was launched in May 2018 to assist practices in executing a formal quality improvement process. CAP helped groups set attainable, short-term goals, and monitored ongoing performance through "tight-loose-tight" methodology supported by expert coaching. Through this methodology, practices worked closely with facilitators to identify key priority quality measures and level-set on expectations. Then the facilitators gave practices the autonomy to develop creative and innovative solutions to meet their quality and cost goals. Following the practice-led design of the strategy, practice facilitators and advisors would monitor progress and provide needs-based support that ensured accountability and supported practices' achievement of their goals.

> Of the 129 practices that participated in the CAP initiative, **95 percent** demonstrated improvement progress towards selected clinical measures based on identified clinical gaps, while **65 percent** demonstrated significant outcome improvements.

QualityImpact worked closely with providers and their care teams to identify opportunities for improvement and design action plans to close gaps in care and improve patient care outcomes. By participating, PTN enrolled clinicians were eligible for CME credits.

Leveraging Clinical Performance Data

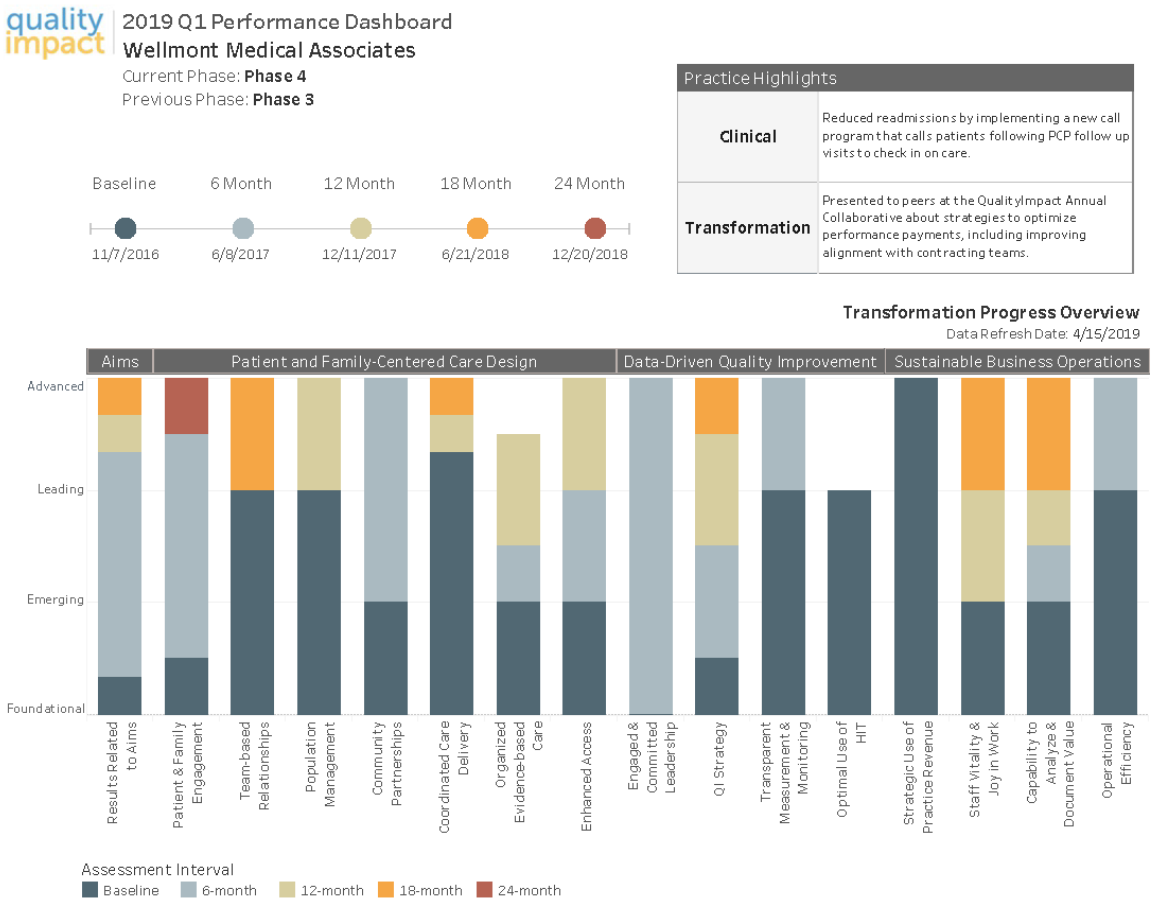
In collaboration with our subcontractor, SPH Analytics, the PTN leveraged clinical performance data across various chronic disease states and upwards of 150 individual measures through the population health management platform, MDinsight (MDI). The platform features multiple capabilities, including:

- Real-time user dashboards with patient-level data, allowing clinicians and care teams to quickly review and evaluate quality measure performance across their high-risk chronic and overall patient populations

- Care gap visualizations with interactive filters to view and manage care status at the individual practice, provider and patient-level
- Workflow support tools like patient care summaries, provider assignment management, automated outreach, and pre-visit planning
- Integrated data sharing across care settings, including primary care and specialist practices

MDinsight also allows clinicians to compare their performance against local, regional, and national PTN benchmarks. Tracking clinician-level data allowed the PTN to identify gaps in knowledge and clinical performance, highlighting clear areas for improvement. In addition, each practice was provided with customized quarterly performance dashboards, highlighting each practice's clinical and phase transformation achievements, including care gaps and opportunities for improvement. Practices' performance was measured as Foundational, Emerging, Leading, or Advanced across categories including aims, patient and family-centered care design, data-driven quality improvement, and sustainable business operations.

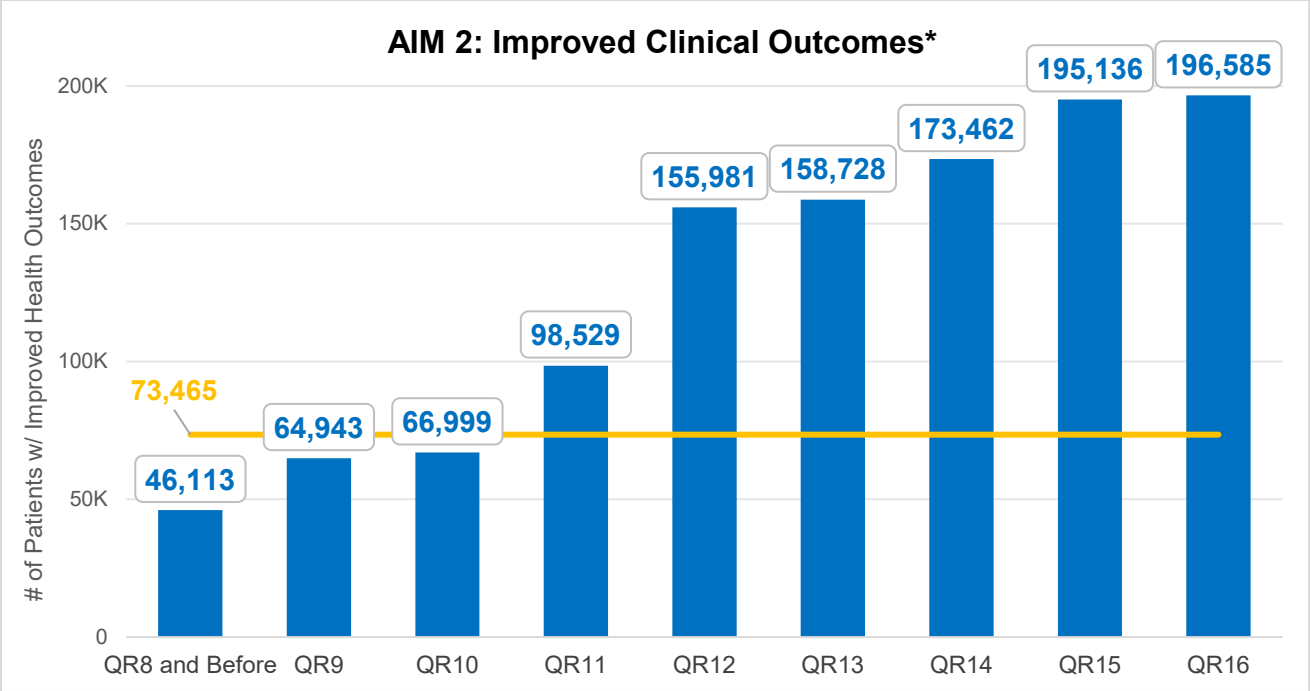
Figure 1.0: Practice-Specific Quarterly Progress Report



Summary of Contributions

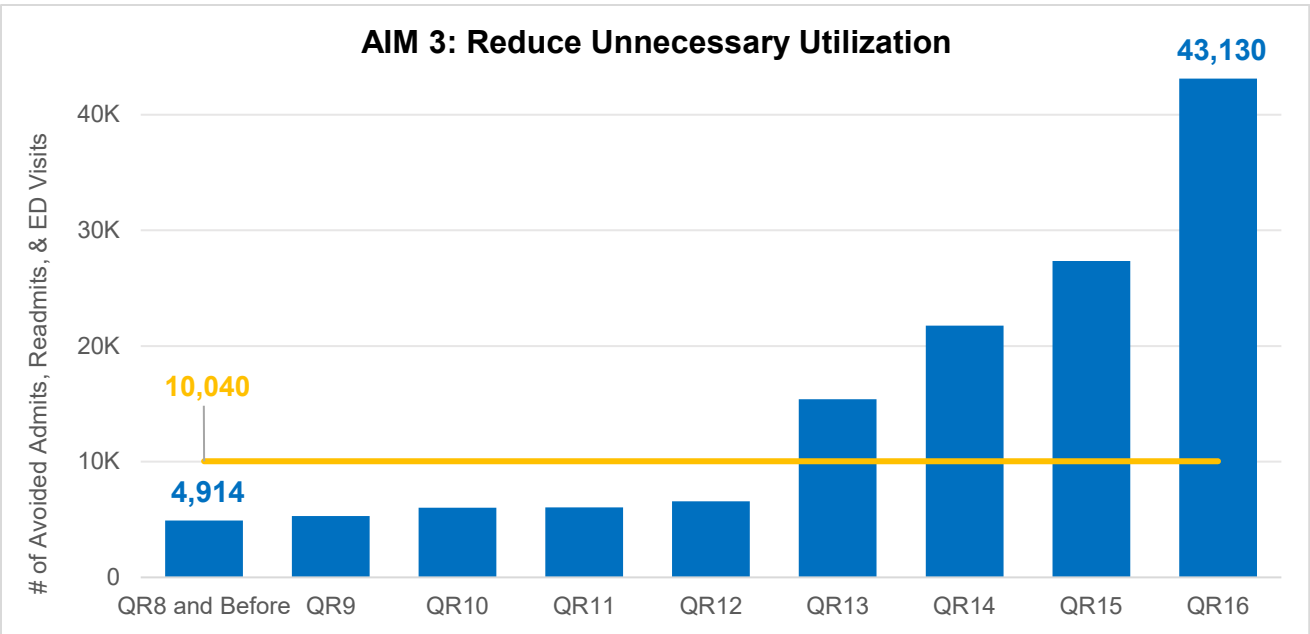
By deploying the strategies highlighted above, QualityImpact saw the following results across the entire PTN population from January 2016 (QR1) to September 2019 (QR16).

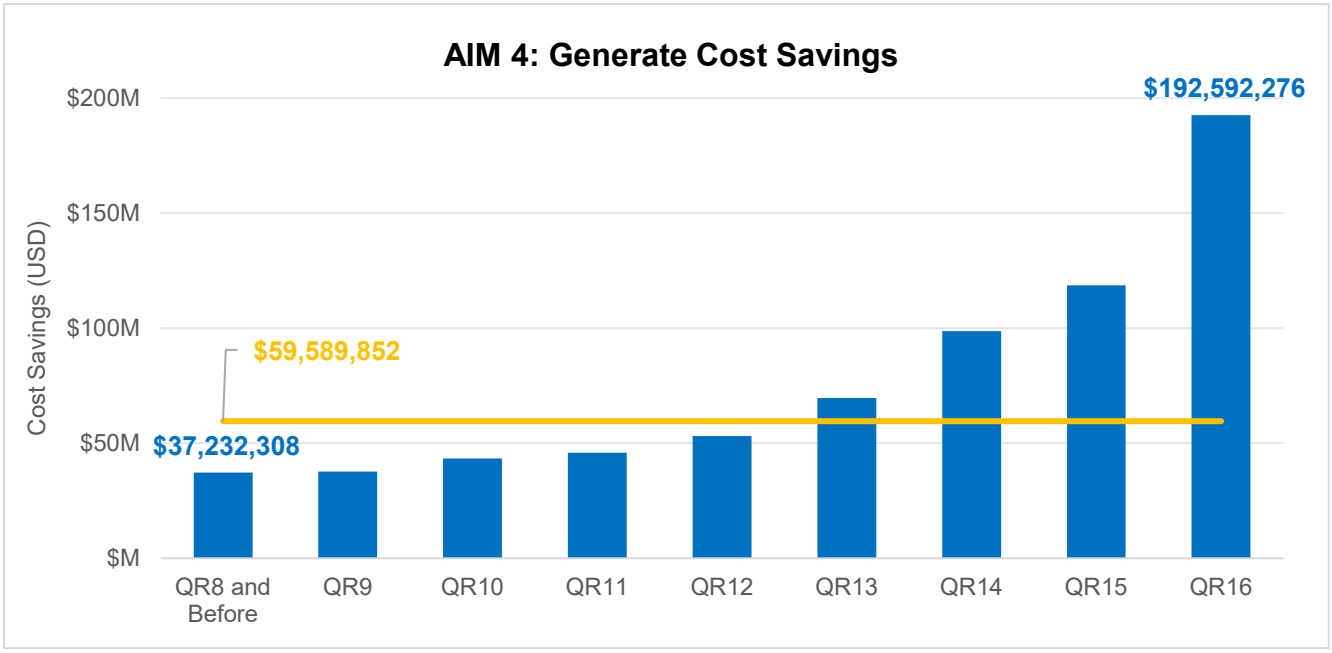
TCPi AIM Contributions

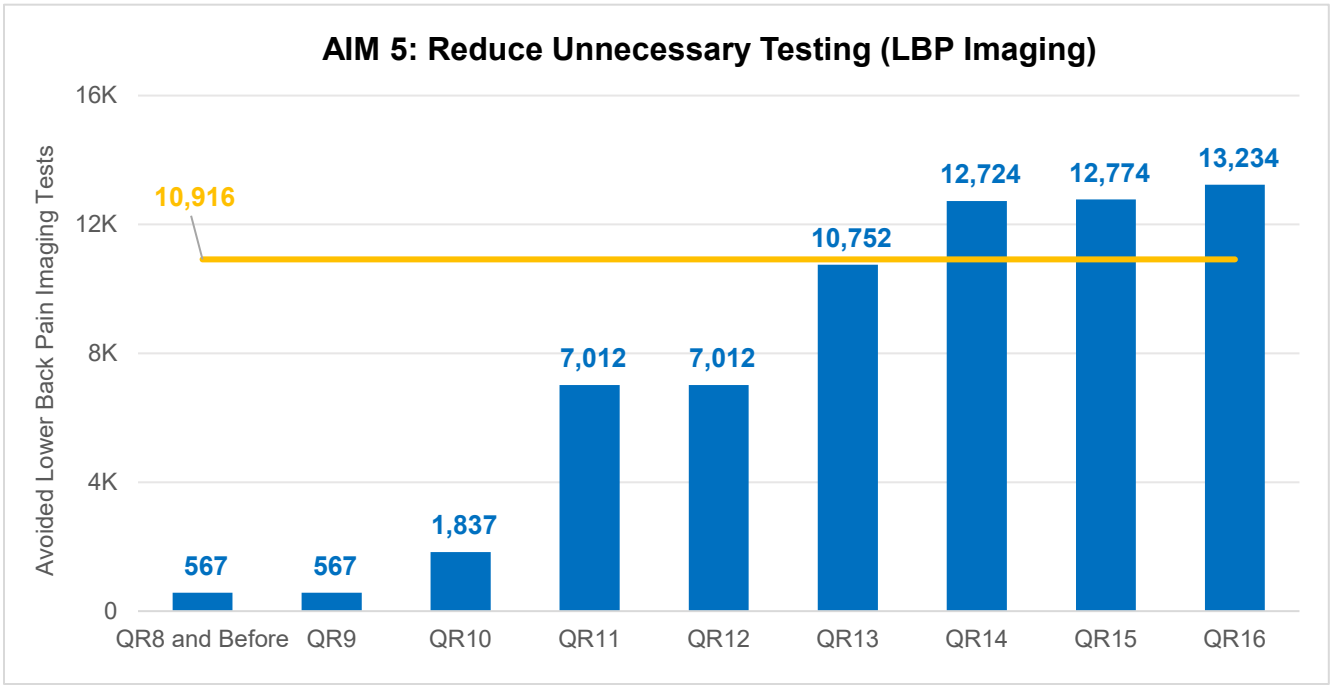


**Improved health outcomes were measured as the # of patients not meeting the clinical measure guideline at baseline that were improved to meeting the clinical measure guideline by September 2019*

AIM 2 Clinical Outcome Measure	Total # of Patients Improved
Hypertension: BP < 140/90 mmHg	105,779
Diabetes: Statin Use	18,098
Diabetes: HbA1c < 8	10,891
Diabetes: HbA1c > 9	4,335







- AIM 2: The y-axis indicates the number of patients with improved health outcomes pertaining to a variety of chronic conditions, including diabetes and hypertension. High-impact measures were used to assess improved health outcomes, such as Blood Pressure < 140/90 mmHg, HbA1c < 8, and Statin Use.
- AIM 3: The y-axis indicates the reduction in the number of unnecessary hospital admissions, hospital readmissions, and emergency department visits.
- AIM 4: The y-axis indicates the cost savings, in USD, generated from improved health outcomes and a decrease in unnecessary utilization of healthcare resources.
- AIM 5: The y-axis indicates the number of unnecessary use of imaging studies for lower back pain imaging tests performed on patients.

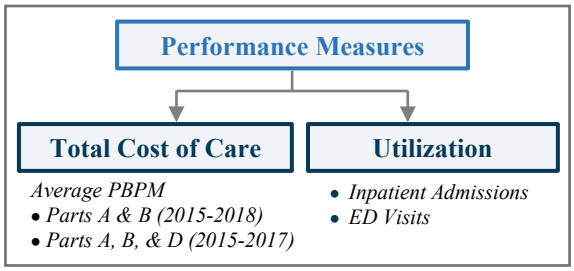
Most Meaningful Contribution

By advancing the PTN's mission to improve cardiovascular care and reduce unnecessary resource utilization, QualityImpact has produced upwards of $192.6 million in cost savings to federal and private payers. As highlighted above, the PTN's most significant contribution has been its ability to act as a catalyst for sustained clinical transformation for all 735 engaged practices across the Southeast. By addressing the unique needs of each practice, the PTN worked together with practice-based clinicians and healthcare teams to design patient-centered care processes and develop the infrastructure needed for lasting results. The 456 recognized exemplary practice sites within the network serve as a testament to the high-caliber organizations within the network dedicated to improving patient care outcomes and the patient experience.

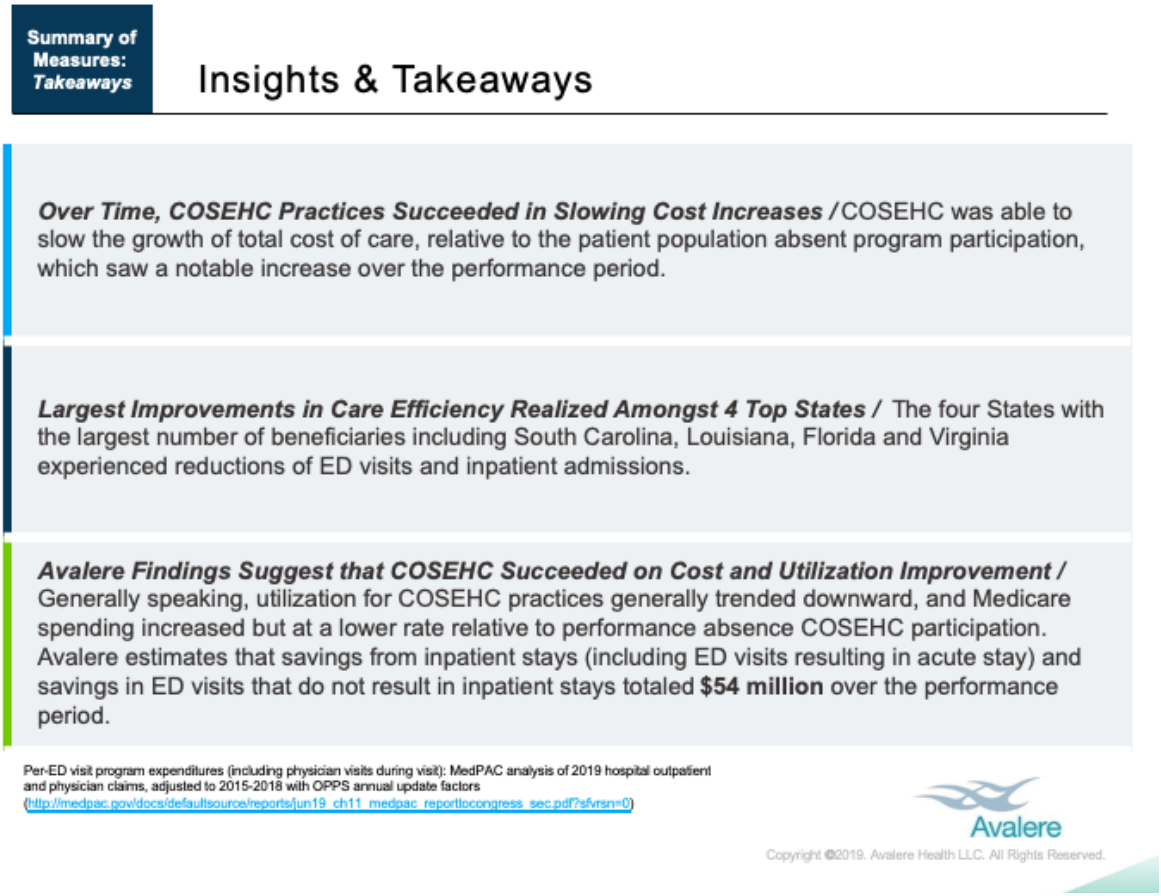
Post-TCPi Utilization & Cost Assessment

To further validate performance, the COSEHC QualityImpact PTN partnered with Avalere Health to conduct a Post-TCPi assessment of Medicare Fee-for-Service (FFS) cost and utilization outcomes for attributed PTN providers from 2015 to 2018. As a CMS Qualified Entity ("QE") operating under the Inovalon Company, Avalere receives a complete Medicare FFS claims data including a 100% sample of Medicare Part A, B, and D. Avalere utilized attribution and statistical benchmarking models from other CMS/CMMI programs and demonstrations to analyze patterns of care among a defined comparison population of all Medicare FFS beneficiaries not attributed to COSEHC PTN practices. Avalere evaluated COSEHC performance on two utilization and two cost metrics (see Step 1 below) from 2015 to 2018, and compared those results against the benchmark population, stratified by year to account for underlying trends in outcomes among the comparison population over time.

The following outlines Avalere's methodology used to evaluate the overall performance of the COSEHC PTN program and relative improvement over time in reducing unnecessary utilization and generating cost savings:



- *Step 1: Identify Measures for Analysis*
  - Avalere and COSEHC identified four key metrics to assess physician performance on generating cost savings and reducing unnecessary utilization
- *Step 2: Attribute Populations*
  - Avalere developed a methodology to attribute beneficiaries to both COSEHC TINs and a population absent program participation, which was established based on COSEHC TIN geographies and plurality of services
- *Step 3: Evaluate Performance*
  - The attributed populations were then evaluated on all identified measures over time (2015 – 2018), with the exception of total cost of care Parts A, B & D, which was calculated using 2015-2017 claims data
- *Step 4: Analyze Results*
  - Avalere refined the identified measures and analyzed results to identify performance trends and evaluate program impact



A) Cost Reduction

Average Cost per Beneficiary per Month, By Participation Year

	COSEHC Population				*Estimated Rate Absent Participation*		
Cost Measure	**Pre-Participation**	**Year 1**	**Year 2**	**Year 3**	**Year 1**	**Year 2**	**Year 3**
Total Cost of Care (Parts A & B) 2015- 2018	$866	$850	$845	$863	$844	$865	$892

Key Takeaway: While the COSEHC population had an increase of 1.5% from participation year 1 to 3, the growth rate was slower than the Avalere estimated absent program participation of 5.6% between years 1 through 3.

	COSEHC Population)				*Estimated Rate Absent Participation*		
Cost Measure	**Pre-Participation**	**Year 1**	**Year 2**	**Year 3**	**Year 1**	**Year 2**	**Year 3**
Total Cost of Care (Parts A, B & D) 2015-2017	$1,109	$1,089	$1,077	--	$1,082	$1,100	--

Key Takeaway: The COSEHC population appears to have realized a slight decrease in total cost of care from participation year 1 to 2 while the estimated rate absent participation shows an increase. However, more longitudinal data would be necessary to see if this trend persist.

B) Utilization Reduction

Rate per 100 Beneficiaries, By Participation Year

	COSEHC Population				*Estimated Rate Absent Participation*		
Utilization Measure	**Pre-Participation**	**Year 1**	**Year 2**	**Year 3**	**Year 1**	**Year 2**	**Year 3**
Inpatient Admissions	31.0	29.4	27.7	26.4	29.5	29.0	28.5

Key Takeaways:
- At a network level COSEHC attributed members had a 10.2% reduction in inpatient admissions between Years 1 to Years 3
- While the rate absent participation also declined, COSEHC providers achieved a larger reduction in inpatient admissions relative to expected admission reduction in the absence of COSEHC participation

	COSEHC Population				*Estimated Rate Absent Participation*		
Utilization Measure	**Pre-Participation**	**Year 1**	**Year 2**	**Year 3**	**Year 1**	**Year 2**	**Year 3**
ED Visits	67.7	65.6	63.8	60.1	67.8	65.0	63.7

Key Takeaways:
- COSEHC attributed beneficiaries had an 8.4% decrease in ED visits from Year 1 to Year 3
- While it appears that the rate absent participation also showed a steady decline in the number of ED visits over the review period, the COSEHC beneficiaries had a greater reduction, down 5.5 ED visits per 100 members by year 3 compared to 4.1

As highlighted above, Avalere results for COSEHC PTN demonstrated reductions in unnecessary resource utilization and increased cost savings across a total of 114,321 Medicare FFS beneficiaries* from 2015 to 2018. In comparison to results of absent participation, COSEHC practice performance generated $54 million in savings from reduced inpatient stays and ED visits during the TCPi performance period. Avalere analyzed utilization and cost data limited to the Medicare Fee-for-Service population, which represents only about 15% of the overall PTN beneficiary population. This validation supports the total cost savings of $192,592,276 reported by COSEHC PTN in September 2019, which factored in savings from other beneficiary populations including an additional 12% Medicare Advantage, 13% Medicaid, 10% Other (uninsured, unknown), and 50% Commercial.

**Note: Average number of Medicare FFS beneficiaries attributed to COSEHC PTN by Avalere during the performance period from 2015 to 2018.*

Significant Results

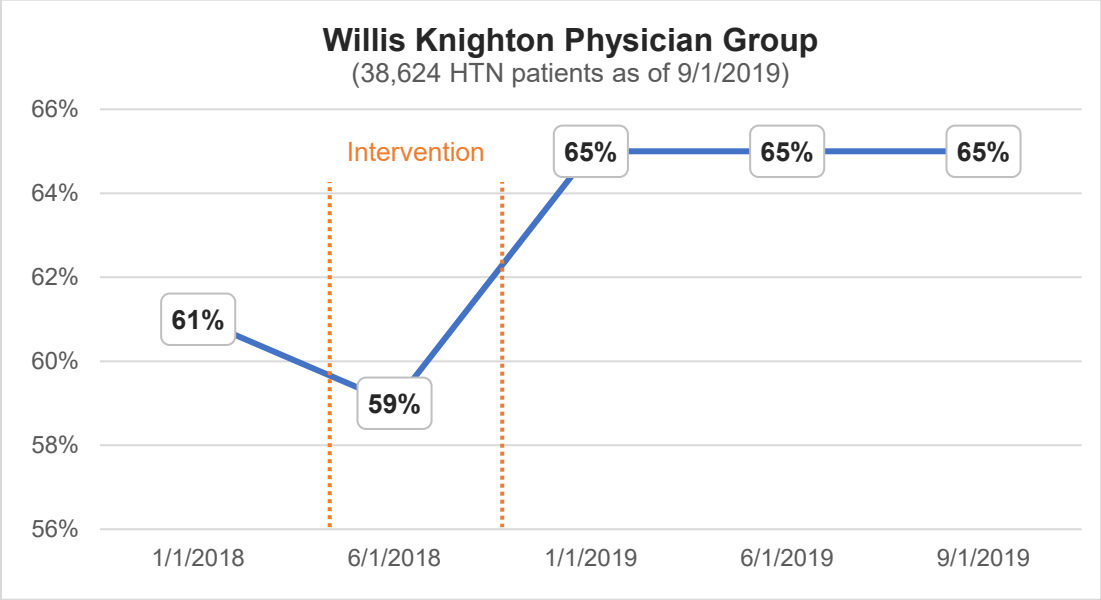
Clinical Measures

The QualityImpact PTN leveraged the MDI population health management tool to track and measure improvements in clinical quality outcomes. This tool integrated data from practices electronic health records (EHRs) to create registries for high-impact measures that can be trended over time. The below details some of the PTNs significant results.

1. **Hypertension: Blood Pressure < 140/90 mmHg**
   PTN practices implemented several strategies to improve blood pressure rates. Primary quality improvement strategies included staff training on blood pressure techniques, transparently sharing clinician-level reports with care teams, using evidence-based guidelines, clinical coaching and designing programs for high-risk patients, such as annual wellness visits and chronic care management services.

   Case Example: Willis Knighton Physician Network

   Willis Knighton Physician Network is a multi-disciplinary health system consisting of approximately 450 clinicians across the Shreveport, Louisiana area. In June 2018 they participated in QualityImpact's CAP program. For this program, they trained staff in blood pressure techniques, worked with every practice to set goals for blood pressure control, and began sharing data transparently across their network. Through the program they improved their blood pressure control from 59% to 65% within the 6-month period and sustained the performance for the rest of the year.

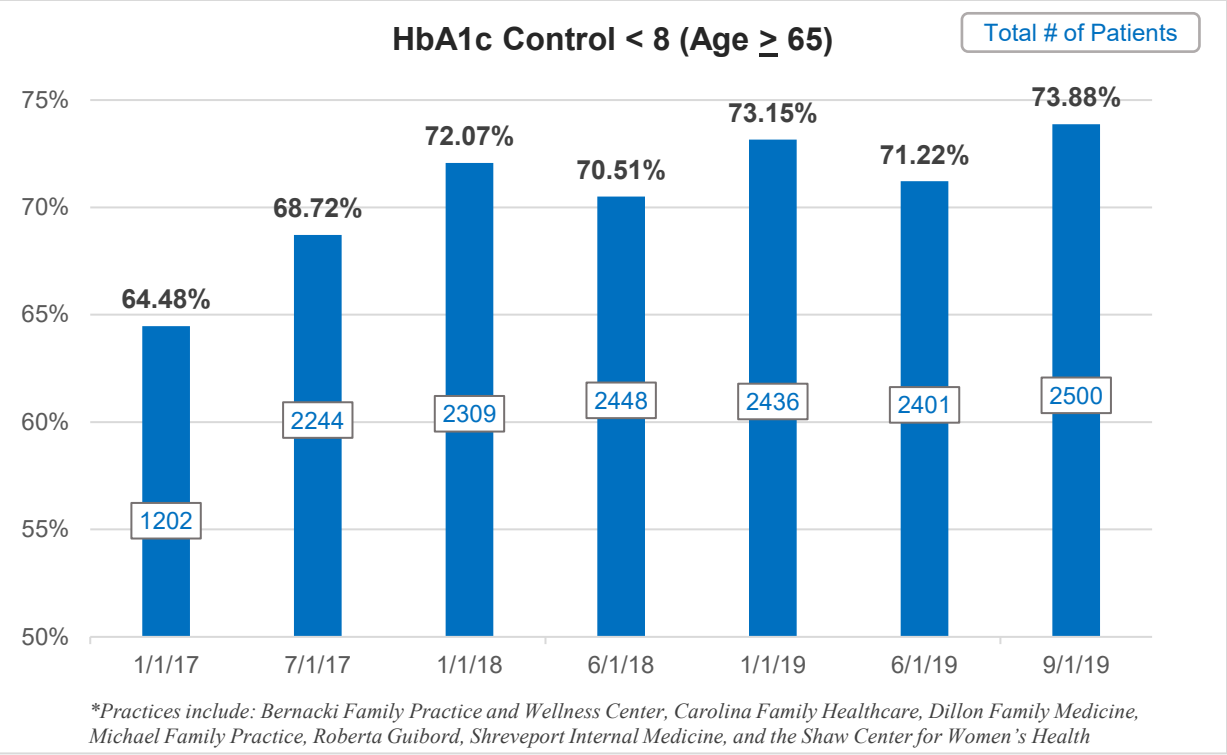


2. **Diabetes: HbA1C < 8 (Age ≥ 65)**
   The QualityImpact PTN tracked A1c performance for the following measures:
   - A1c < 7 (Age < 65)
   - A1c < 8 (Age ≥ 65)
   - A1c < 8
   - A1c > 9 (poor control)

Core strategies to improve A1c performance included establishing risk criteria, outreaching to high and at-risk patients, implementing management protocols including frequency of visits, clinical coaching and incorporating self-management strategies (e.g., obesity management programs, diabetic education specialists, and patient workshops).

Case Example: Groups With <15 Providers Across the Southeast

The below groups initiated these strategies during their CAP program starting in June 2018. These groups ranged in size from solo practitioners to multi-disciplinary practices with up to 12 providers, all of which were recognized for achieving Exemplary Status as reported in the CMS National Registry. After implementing the intervention, practices saw a 3% improvement over the measurement period.



**Practices include: Bernacki Family Practice and Wellness Center, Carolina Family Healthcare, Dillon Family Medicine, Michael Family Practice, Roberta Guibord, Shreveport Internal Medicine, and the Shaw Center for Women's Health*

3. Ischemic Vascular Disease: Statin Use

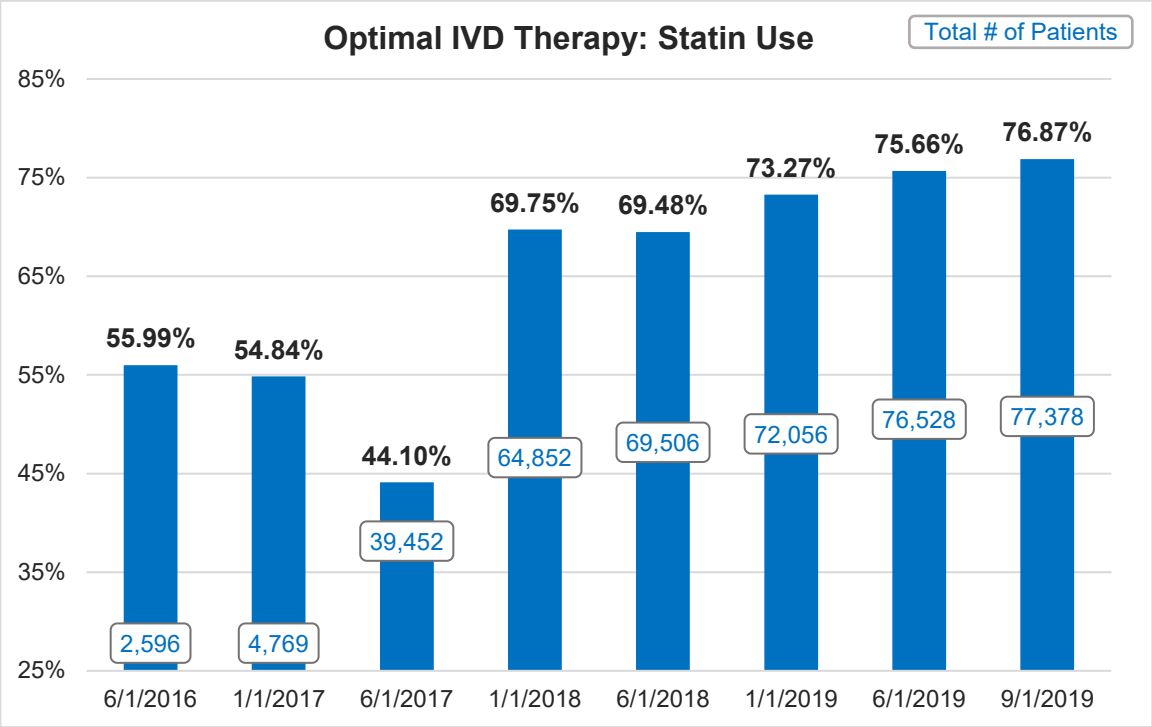
A key learning of the QualityImpact PTN was the importance of data capture and transparency in order to ensure that quality measures were met. One measure where the impact of this was very evident was Statin Use for patients with Ischemic Vascular Disease.

By implementing the MDI population health management tool, practices were able to identify patients in need of a statin based on their diagnosis and associated risk indicators. This transparency drove providers to formalize protocols for initiating and managing statin therapy. MDI streamlined access to key patient-level information related to IVD treatment, including LDL control levels, and highlighted measures like Statin use based on the latest evidence-based care guidelines.

This data transparency, combined with implementing pre-visit planning and ongoing monitoring of at-risk populations, resulted in a 21% increase in Statin Use for IVD patients across the network over the three-year period. Only 7 organizations had baseline scores at or above the QualityImpact PTN's target of 75%. However, at the close of the program, 35 organizations had met or exceeded the target.

Case Example: QualityImpact PTN Practices

The below chart represents data from all of QualityImpact PTN's practices using the MDinsight population health management platform. Organizations went live on the system as they completed implementation, with almost all leveraging the platform by January 2018. Amongst significant population growth, primarily driven by the enrollment of new practices, QualityImpact improved Statin Use across all Ischemic Vascular Disease patients by 27% to achieve the current 77% performance rate (as of September 2019).



Section 3: Challenges and Lessons Learned

Challenges Under TCPi

The QualityImpact PTN experienced a number of challenges over the course of the TCPi demonstration, including:

1. **Lack of Medicare Claims Data**: Under TCPi, the QualityImpact PTN did not receive or have access to Medicare Claims data, making it difficult to fully understand the impact of technical assistance on Medicare utilization and cost trends. Therefore, utilization and cost estimates were based on claims-based utilization reporting provided by a dominant Southeastern commercial payer to the PTN. Resulting changes in utilization and cost performance were extrapolated across the Southeastern PTN network utilizing CMS-approved methodology, supported by the majority commercial presence representing almost one-half of the total PTN patient population. Medicare performance rates and cost trends provided by CMS to the PTN through The Engagement, Transformation, Results (ETR) Reports illustrated trends similar to those measured in claims reporting from the dominant commercial payer partner. The PTN segmented commercial payer rates for 50%

of the total PTN patient population and utilized ETR performance rates for 27% of the total patients covered under Medicare starting in QR13, based on approval from the designated CMS Project Officer. Using this methodology, QualityImpact was able to offer a more holistic view of the total PTN patient population and reflect appropriate cost and utilization performance for the respective payer types.

2. **OPAT Reporting:** Due to ongoing changes to the requirements and technical issues while using the Online Practice Assessment Tool (OPAT), the PTN redirected significant resources to be able to successfully meet all CMS requirements for reporting practice assessment data collected during the four-year program. QualityImpact worked closely with the Data Support and Feedback Report (DSFR) Team to proactively address technical issues and new requirements while acknowledging that those resources would have been dedicated to furthering the transformation work with enrolled practices.
3. **Cloud-Based EHRs:** The PTN faced a number of challenges when trying to import clinical data from unique, proprietary EHR systems, especially if they were cloud-based. As a result, QualityImpact had to engage in other methods of evaluating practice-specific clinical performance, which often required practices to send the PTN their EHR generated reports, HEDIS performance measures, and/or claims report. These reports were not as robust as the clinical data generated from the PTN's Population Health IT platform, MDI.
4. **Revision of Utilization Measurement Commitments**: In Year 3, QualityImpact revised its utilization measure commitments to adjust for a predominantly commercial patient population. The initial commitments were made early in TCPi when the PTN expected a larger mix of Medicare patients, but as the initiative progressed, the PTN recognized that over half of its patient population was enrolled in commercial plans, making the initial commitments unrealistic.
5. **Exceeded Enrollment Commitment Without Receipt of Additional Funding:** QualityImpact is proud to announce it exceeded its final enrollment commitment by 16 percent. In QualityImpact's original TCPi application, the PTN committed to 3,407 enrolled clinicians and built its budget to support that enrollment. While the higher enrollment stretched PTN resources, QualityImpact created innovative ways to provide technical assistance, including: facilitating live and virtual LANs, launching rapid-cycle PDSA (Sprint and CAP) initiatives to accelerate progress, developing and distributing progress dashboards which practices used internally to drive transparency and data-driven quality improvement, and promoting peer-to-peer learnings and best practices.
6. **Trending Performance Improvement, From Baseline to End of TCPi:** The PTN found it challenging to reflect overall PTN performance trends from baseline due to rolling practice enrollment. In future projects, the PTN recommends beginning the baseline measurement period after all recruitment activities have concluded, allowing all practices within the network to begin at the same time.

Lessons Learned

- **Extensive Collaboration**: Under TCPi, the QualityImpact PTN promoted collaboration across the network, encouraging enrolled clinicians to engage the PTN's extensive network of subject matter experts and support colleagues. The PTN recognized that collaboration was essential to provide a broad spectrum of services and resources to clinicians and facilitate peer-to-peer learnings, which created the most significant impact on the network.

- **Early Adopters**: Early in the demonstration, the QualityImpact PTN acknowledged the value of leveraging early adopters to promote transformation progression within practices and across clinically integrated networks. Surprisingly, these early adopters were not always in top leadership roles. The PTN worked to identify and support these early adopters, ultimately sharing their successes across the network.
- **Early Expectations**: To ensure successful partnerships, QualityImpact worked with practices early on in the engagement process to align expectations. Upon enrolling in the PTN, the practices signed a letter of agreement, clearly outlining accessible PTN services and resources and the level of engagement the PTN expected of the enrolled practice. This helped to build accountability and trust between the practices and the PTN throughout TCPi.
- **Continual Feedback**: Practices within the PTN were most engaged when provided consistent and ongoing feedback. Upon enrollment, PTN facilitators and practices co-developed action plans designed to drive transformation and achieve quality measure goals. Facilitators would then regularly check-in with practices and provide data-driven, actionable feedback based on the practices' clinical metrics performance and phase progression. This facilitation model provided practices the opportunity to continuously review and refine action plans to optimize patient outcomes.
- **Operationalizing Data:** Early in the TCPi demonstration, the PTN recognized the value of analyzing and visualizing data in lean, actionable reports after receiving feedback from clinicians that extensive, in-depth reports were generally ignored. Thus, the PTN developed brief 1-2 page reports that leveraged visualizations highlighting the most impactful data, opportunities for improvement, and recommendations, which were distributed to practices quarterly.
- **Clinician Coaching**: The QualityImpact PTN leveraged its network of clinical subject matter experts to provide coaching opportunities for PTN enrolled clinicians. The PTN linked practice leaders to one-on-one support from clinical experts through a variety of mediums, including on-site visits, webinars, and the live Annual Learning Collaboratives. The PTN received extensive positive feedback from clinicians utilizing this service.
- **On-Site Visits**: In an effort to build lasting partnerships, QualityImpact visited each enrolled practice on-site at least once. Additional on-site visits were then planned to re-engage practices falling behind on communications or progress toward aims, providing the PTN the opportunity to re-align on expectations and priority areas.
- **Peer-to-Peer Sharing**: The PTN optimized outcomes by promoting best practices from high performing practices and creating opportunities for them to share their lessons learned through LANs, webinars, and one-on-one coaching. These best practices could then be scaled across the PTN network, which garnered great support from practices and clinical leadership alike.
- **On-Demand Learnings:** After establishing relationships with practices through the on-site visits, the PTN developed a number of on-demand educational resources, allowing clinicians to weave them into their daily schedule. The PTN recorded all live offerings, such as webinars, and archived them to build an extensive on-demand learning library. Additionally, QualityImpact recorded the live Annual Learning Collaborative and archived the slide decks for later on-demand use. This allowed the PTN to provide services to all

practice team members even if they were unable to attend the scheduled live events. The PTN found this to be a very effective way to reach all of the enrolled clinicians.

Section 4: Planned Activities

QualityImpact Champions'(Alumni) Network

Upon sunsetting of TCPi, the PTN will continue to engage practices though the QualityImpact Champions' Network, an association of practices across the Southeast dedicated to transforming clinical practices by leading the transition to value and innovating patient-centered care solutions. The network will provide members access to key resources developed under TCPi and archived, including billing and coding modules, toolkits and resource guides on topics covering APMs, MIPS, and marketing, and archived webinars hosted by QualityImpact Advisors. Members will be encouraged to continue the conversation around quality improvement and best practices by discussing successes and lessons learned from past initiatives through the discussion forum in the portal.

Centers of Excellence

In addition, COSEHC will continue its mission to eliminate cardiovascular and metabolic diseases by fostering its longstanding relationships with its 33 Centers of Excellence and expanding the program. The COSEHC Centers of Excellence program is a network of academic health centers and community primary care practices dedicated to achieving excellence in cardiovascular care in areas of lipids (LDL), blood pressure, and A1c control. The network will continue the COSEHC mission to eliminate cardiovascular and metabolic diseases by continuing to offer continuing medical education (CME) opportunities, facilitate best practice sharing, providing consultation to facilities within the network, and supporting innovative clinical research in the diagnosis and treatment of diseases of the heart and blood vessels.

CMS NQIIC Awardee

COSEHC was named as one of the 59 organizations selected to be a NQIIC Indefinite-Quantity (IDIQ) federal contractor. As an NQIIC IDIQ, COSEHC intends to continue its quality improvement activities to support practices in transitioning to value by improving patient-centered care delivery and implementing cost management and control strategies. COSEHC submitted a proposal for TORP 2 in August 2019, and if awarded, looks forward to providing technical support to a forecasted network of clinicians across the Southeast.

Continued Commitment to Clinical Transformation

Over the past four years of the TCPi demonstration, QualityImpact has equipped practices with the tools, knowledgebase, and peer support network for continued clinical transformation. After the sunset of TCPi, the PTN is confident the practices will continue their quality improvement activities independently.

While not an exhaustive list of planned practice activities, common initiative themes include:

- **Enhanced Community Communication and Engagement:** In an effort to improve care continuity for patients, various practices are continuing efforts to enhance communications between community stakeholders and organizations, including primary and specialty clinicians coordinating the care of chronic care patients. For example, GastroIntestinal Specialists in Shreveport, Louisiana, anticipates continuing its popular referral workshop, which provides an opportunity for primary and specialty care providers within the community to get together and optimize the referral process by breaking down barriers to care continuity. Closing the loop on incoming and outgoing referrals has resulted in fewer missed chronic disease appointments and improved continuity of care for patients.
- **Emphasis on Provider Education**: Transformation champions recognize the importance of provider education and buy-in in the transition to value. Across the PTN, practices are providing clinicians and care teams education on key principles of success in value-based care arrangements. In particular, Wellmont Health System plans to continue its popular annual billing and coding training for physicians, in which it identifies solutions to common challenges facing providers.
- **Refinement of Care Management Systems:** Many organizations within the network have designed and successfully implemented the foundational pillars of care management, including performance measurement, risk stratification, care coordination, data integration, and patient engagement. Building on that infrastructure, practices will continue to formalize collaborative systems for care management to support improved patient care and organizational performance within value-based payment models. A leading example is Lee Health System, which continues to refine and optimize its care management systems by integrating new data sources, risk stratification methodologies, and models for analyzing care team performance.

Section 5: Stories from the Field

Quality Improvement Innovations

As indicated in Section 2, the QualityImpact PTN realized great success in improving quality outcomes and reducing unnecessary resource utilization. While prior to the accelerated quality improvement initiatives, the PTN was experiencing gradual improvement consistent with expectations, QualityImpact was focused on exceeding all goals across each TCPi AIM through targeted interventions. The PTN developed two accelerated quality improvement initiatives, the 2017 Performance Improvement Sprint and 2018 Clinical Action Program (CAP), which demonstrated substantial improvement across quality and cost measures. The CAP initiative built upon the successes of the performance improvement sprint, engaging 129 practices in accelerated performance improvement, and putting the PTN on track to exceed goals across aims.

Common themes across the initiatives included care team engagement, patient education and outreach, and improving chronic care management for diabetes and hypertension populations. However, a few practices' interventions stand out due to the immense community support they garnered. Southern Medical Care, an Occupational and Family Medicine practice dedicated to providing affordable care to the greater Hattiesburg, Mississippi community, launched a number of community outreach programs aimed at improving patient education and promoting healthy

lifestyle changes for their diabetic population. Southern Medical Care's seasonal Lunch and Learn event promotes patient education for diabetics, including nutritional counseling services. The practice soon gained regional awareness when a local news channel picked up their story to cover their collaboration with Katie Dixon, a Master Chef competitor, who partnered with the practice to prepare nutritional, diabetic-friendly meals. In addition, the practice promoted cardiac health initiatives, providing patients access to HeartCare Channel educational videos. The most engaged patient was then awarded a Fitbit to support their health journey.

Willis Knighton Health System (WKHS), serving upwards of 94,300 patients in the Arkansas-Louisiana-Texas region, launched a Sprint performance improvement plan with the aim to improve communication and care coordination, address challenges relating to data sharing across the network, and increase provider engagement. Over the course of the Sprint performance period, WKHS experienced a 31 percent decrease in admissions and an eight percent decrease in unnecessary ER visits. In addition, the improved quality improvement infrastructure contributed to a five percent network-wide improvement of hypertension control.

By providing practices the opportunity to earn financial incentives through quality improvement initiatives, QualityImpact created a win-win-win scenario for the PTN, the clinicians, and the network of over 2.1 million patients.

Learning Collaborative

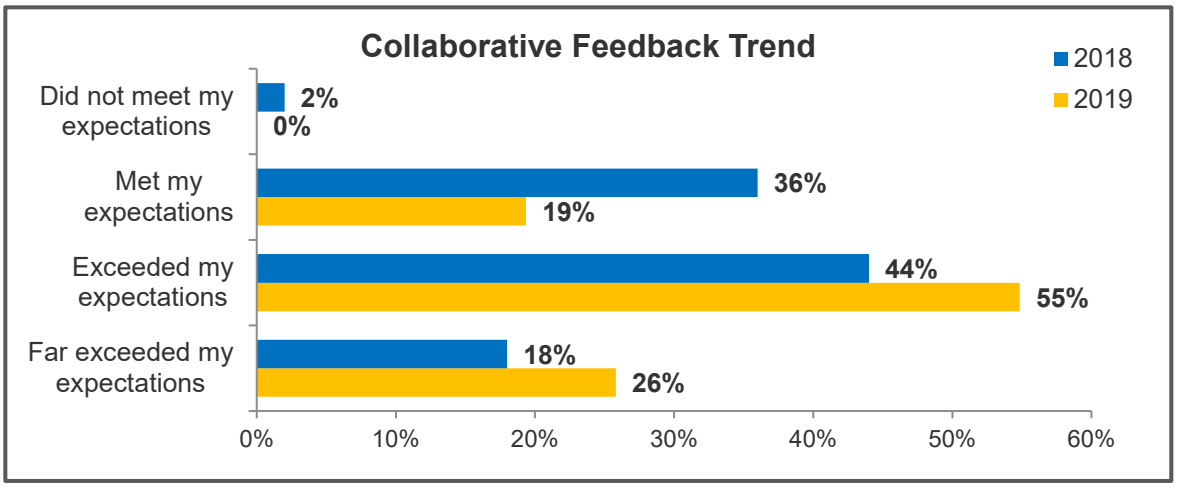
Early on under TCPi, QualityImpact received great demand for peer-to-peer learning opportunities from practices and recognized its impact on performance improvement and clinician engagement. QualityImpact aimed to leverage its network of engaged practices and clinical leaders by hosting Learning Collaboratives. Featured speakers shared key insights on the successful transition to value, regulatory considerations, and more. Attendees participated in panel discussions, roundtable discussions, and interactive workshops aimed at building a knowledge base around annual themes, including:

- **The World of Value – Accelerating Performance and Celebrating Success (2019)**
  - Session Topics: Business case for sustainable transformation, keys to success under risk arrangements and value-based partnerships, improving joy in medicine, strategies for substance use disorder, best practice care models for healthcare teams, enhancing reimbursement through optimizing billing and coding, implementing hypertension and lipid guidelines, integrating behavioral health in clinical practices, improving care management and continuity of care, improving patient engagement, optimizing performance payments, building a medical neighborhood, supporting lifestyle and sustainable medicine, and keys to success under new payment models.
- **Transforming Care to Optimize Health Outcomes (2018)**
  - Session Topics: Healthcare reform and the regulatory landscape, the value-based continuum, industry trends, data-driven change and quality improvement, managing post-acute care to reduce unnecessary costs, evidence-based guidelines update, building an optimal telehealth and telepsych model, implementing chronic care management, reducing variation in care, succeeding under APMs, measuring, and improving patient and family engagement.
- **Succeeding in Value-Based Healthcare (2017)**

- Session Topics: Payment reform and predictions, the Quality Payment Program, chronic care management strategies, improving clinical documentation, leveraging PCMH as a clinical practice improvement activity, keys to successful value-based transitions, leveraging data in population health management, integrating behavioral health in primary care, establish a medical neighborhood, and understanding cost and value equitation.

High-performing practice leaders were also recognized for their achievements across 14 award categories. For example, Dr. Daniel W. Jones, Director of Clinical and Population Science at the Mississippi Center for Obesity Research and Professor of Medicine and Physiology at The University of Mississippi Medical Center, was awarded the COSEHC 2019 Lifetime Achievement Award for his work in hypertension and cardiovascular disease. Dr. Jones served as the national president of the American Heart Association from 2007 to 2008 and has been practicing medicine for over 40 years. Likewise, another national leader in hypertension, Dr. Robert Carey, Dean Emeritus at the University of Virginia, received the COSEHC Leadership Award. Both Drs. Carey and Jones were contributing task force members, which developed the American Heart Association/America College of Cardiology 2017 Hypertension and 2018 Cholesterol Clinical Practice Guidelines.

Each year, the PTN refined its approach based upon feedback provided in the Annual Collaborative surveys. Practices largely expressed their appreciation for the opportunity to engage directly with peers and experts, allowing them to continue to build a knowledge base around value-based activities to accelerate clinical transformation. The positive impact of these changes is evident in the below graph:



QualityImpact saw an overall positive shift in the feedback received related to the final collaborative in 2019 compared to prior years.

When capturing feedback, practices were asked to share a topic or learning they would like to implement in their practice after the collaborative. The responses turn into a collaborative discussion between practices and their respective facilitators. The top responses for 2018 and 2019 are shown in the table below:

Key Takeaways for Practice Implementation	
2018	• Improving billing and coding for reimbursement • Implementing care management and CCM • Controlling blood pressure and hypertension
2019	• Engaging clinical teams in care models • Optimizing value-based payments • Integrating behavioral health in primary care

QualityImpact created resources for the top topics of 2019, including APM preparation and negotiation toolkit and an archived coding webinar series hosted by Dr. Nick Ulmer, QualityImpact Clinical Advisor. These resources were developed to help practices moving forward, even after the TCPi has come to an end.

Billing and Coding Modules

Upon receiving great demand for additional billing and coding support, the QualityImpact PTN collaborated with Dr. Nick Ulmer, a practicing physician at Spartanburg Regional Healthcare System and founder of the ProTime e-Learning Platform, to develop a billing and coding educational series on six topics:

1. Understanding Evaluation and Management Guidelines
2. Medicare Wellness Visits
3. Chronic Care Management and Clinical Applications
4. Transitions of Care Coding and Applications
5. Quality Measurement and MACRA
6. Understanding HCC Risk Scoring

Each module was designed to strengthen users' understanding of medical decision making, coding, and recommended documentation for correct patient encounter billing. Participants were awarded up to 1.0 CME credit for successfully completing each module and corresponding post-test. The billing and coding modules received widespread support from practices across the PTN, with 179 registered users.

Practice Transformation Stories

In the final months of the TCPi demonstration, QualityImpact recognized practices would benefit from additional peer-to-peer support in exceeding aims and resources to help practices showcase their achievements under TCPi.

To address the PTN's needs, QualityImpact launched a three-part APM Readiness Bootcamp series to further support and boost practices' transition to value. Sessions covered key components for a successful transition to value and featured QualityImpact Advisors and high-performing alumni practice leaders. Speakers highlighted lessons learned in transitioning to value-based arrangements and key considerations for practices planning to transition. Speakers and focus areas included:

- *Terry McGeeney, MD, MBA*, QualityImpact Transformation Advisor and value-based expert, identified common barriers, key elements of preparedness, and best practices
- *David Uptagrafft, MBA*, Director of Operations at Innova Primary Care, a QualityImpact graduate and MSSP participant, shared insights and tested solutions for risk-based coding, scoring and documentation
- *Kristine Fay, MHA*, Chief Administrative Officer at Lee Physician Group, a QualityImpact graduate, discussed key lessons learned from Lee's journey in creating their Next Generation ACO, including best practices for risk stratification and care management

Practices were provided the opportunity to engage with alumni who had recently transitioned to APMs, and discuss lessons learned and keys to a successful transition. In addition, practices were provided supplemental APM guides and FAQs to aid in their transition. Combined with QualityImpact advisor's market research to identify APM availability for each practice, the PTN experienced great success in aiding practices transition to value.

Section 6: Pulse Check

COSEHC would like to thank CMS for the opportunity to participate in the TCPi program and looks forward to continued engagement under NQIIC. The TCPi program has received positive feedback from the clinicians and care teams engaged throughout the program. Many groups praised the model and support that the program provided them.

In reflecting on key learnings for future initiatives, QualityImpact largely attributes its success under TCPi to its nimbleness as a team and the flexibility of its quality improvement model, which has allowed the PTN to quickly address emerging challenges and meet the ever-changing needs of the network. The COSEHC team and partners also worked seamlessly to assess the needs of the practices within the PTN and adapt the approach or resources to meet the individual needs of each enrolled practice wherever it may be in the transition to value-based care. For example, in assessing practices' progress toward aims, the QualityImpact PTN adapted the practice assessment tool to enhance its ability to serve as a facilitation tool in guiding discussions around value-based care competencies. These assessments used practice-friendly language to meet practices where they were in their care journeys, using a semi-structured approach to guide practices toward furthering aims while providing them the flexibility to incorporate their own interests in action plans.

Section 7: Final Report Close Out

A. Provide a description of the major activities that occurred during the three-year award period.

As detailed in Section 2, major activities that occurred during the three-year award period included:

- **Recruitment and Onboarding:** Led by clinician leaders and recruitment specialists, QualityImpact's recruitment and onboarding processes were optimized to gain provider and care team buy-in, identify shared priorities, align on performance goals, and build a strong foundation for continued clinical transformation. Recruitment specialists took a systematic approach in identifying individual practice needs, co-developing action plans, and closing gaps in care. The recruitment and onboarding process provided a comprehensive welcome package to practices, streamlining and expediting their integration into the PTN.
- **Customized Action Plan:** QualityImpact worked closely with clinical practice transformation champions from each practice to address their individual culture and performance improvement opportunities. By acknowledging the needs of practices across the network will vary, QualityImpact's no one-size-fits-all approach helped the team efficiently deploy appropriate support resources, including QualityImpact advisors and SMEs, providing one-on-one clinical transformation support to practices.
- **High-Touch Facilitation**: PTN facilitators worked closely with the practices to identify existing and emerging opportunities for improvement, develop interventions and action plans, provide technical support and expertise, evaluate progress toward aims, and refine action plans as needed. Facilitators then identified some of the highest performing practices and helped those practices share their insights across the network, promoting the scaling of best practices.
- **Learning Collaboratives:** Annual Learning Collaboratives helped the QualityImpact PTN to develop an extensive knowledge base of keys to successful value-transformation and scalable patient-centered care solutions. Covering topics including accelerating performance and celebrating success in the world of value, transforming care to optimize health outcomes, and succeeding in value-based healthcare, the Collaboratives facilitated peer-to-peer learnings and sharing of best practices across the PTN.
- **Clinical Coaching:** QualityImpact's extensive network of subject matter experts provided clinical leadership with one-on-one coaching and webinars on key PTN areas of interest including billing and coding, HCC risk coding, APM readiness, and more. In addition, the PTN provided practices customized support by identifying gaps in performance and linking practices to appropriate live collaborative faculty based on the practices' individual needs.

- **Engaging Key Stakeholders:** Throughout TCPi, QualityImpact engaged a wide array of stakeholders including front line providers and care teams, administrators, IT staff, analytics specialists, payers, SANs, QIOs, and other PTNs in the transition to value. To facilitate broader learnings across the network, practices were divided into peer groups according on common gaps in clinical measures, practice size, and geographic locations. These groups then developed strategies for closing gaps in care and improving patient care outcomes. Subject matter committees, for example, the behavioral health subcommittee and care management work groups were formed with the aim to identify best practices and share evidence-based guidelines across the PTN.
- **Accelerating Quality Improvement:** In an effort to accelerate performance outcomes, QualityImpact launched two six-month quality improvement initiatives, the Clinical Action Program (CAP) and Performance Improvement Sprint, to practices improving quality and cost measures across a number of categories including diabetes blood sugar control (HbA1c<9), hypertension management (BP<140/90 mmHg), and more.
- **Leveraging Clinical Performance Data:** In collaboration with SPH Analytics, QualityImpact leveraged the population health management system, MDinsight, to provide clinicians real-time data demonstrating their clinical performance compared to PTN-wide performance. The data transparency allowed clinicians to quickly identify care gaps down to the patient-level and provide patient outreach and linkage to care.

A. Indicate the reasons for omissions and changes in major project activities.

As explained under Section 3 and further explained below, the PTN changed its utilization target goals. Additionally, around the same time, the PTN aligned with NQF definitions of clinical measures. Prior to that alignment, QualityImpact was tracking the same measures by condition rather than across the total applicable population as defined by NQF. For example, hypertension control was reported according to four different conditions: Hypertension, Heart Failure, Chronic Kidney Disease, and Ischemic Vascular Disease, which reflected the duplication of patients.

In 2018, QualityImpact worked with its CMS Project Officer to reevaluate measure commitments for AIM 3: Reduce Unnecessary Hospital Use and AIM 5: Reduce Unnecessary Tests and Procedure. Original measure commitments were based solely on commercial patient populations at baseline, so the PTN made revisions to take into the total patient population within the network, including a sizeable Medicare population with a different utilization profile. As recommended by the CMS Project Officer, QualityImpact made the following revisions to commitments in December 2018 to align the committed number of improved cases to the actual contributing and applicable populations for utilization measures.

Measure	**Old Commitment** (Baseline – 12/2018)	**New Commitment** (12/2018 – 09/2019)
Aim 3: ED Visits	17,583 reduced cases	6,062 reduced cases
Aim 3: Overall Admissions	10,796 reduced cases	3,470 reduced cases
Aim 3: Readmissions	730 reduced cases	508 reduced cases
Aim 5: Imaging Studies for Low Back Pain	13,411 reduced cases	10,752 reduced cases

B. If project performance was affected by changes in key project personnel, explain why the changes were made and how performance was affected.

Not applicable.

C. For projects involving computer applications, describe any changes that were made in the method of data entry, the specific data to be encoded, software, hardware, file systems or search strategies.

Not applicable.

D. Briefly describe any efforts that were made to publicize the results of the program.

The results of the program were distributed through a variety of mediums, including press releases, webinars, newsletters, and targeted messaging to individual practices. All information released to the public was reviewed and approved by CMS. Practices were encouraged to share their participation and further expand the PTN outreach efforts to publicize the results of the program through a PTN-developed Marketing Toolkit, providing practices the background knowledge and templates necessary to publicize their successes through a variety of mediums. Practices were also encouraged to share their exemplary practice stories within their local communities to highlight their role in improving the health and well-being of their patient populations.

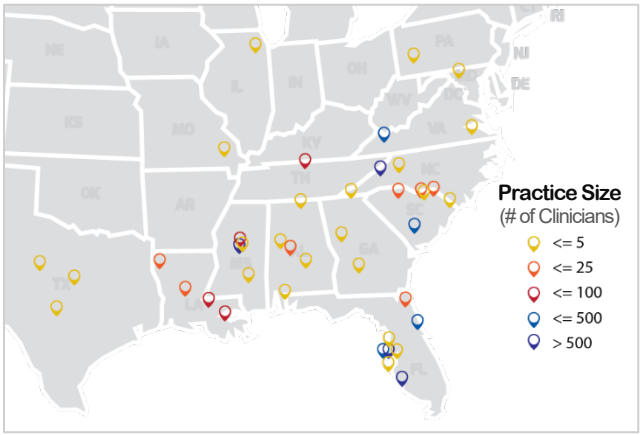
QualityImpact and SPH Analytics developed a joint case study (approved by CMS prior to publication) highlighting the impact the MDinsight population health management platform had on improving data transparency and providing clinicians actionable data. In addition, Dr. Paul Rosen encouraged one of QualityImpact's pediatric practices to develop a manuscript detailing their exceptional performance, and the manuscript was recently submitted to CMS for review and approval. Finally, the PTN plans to develop a manuscript highlighting its 4-year performance under TCPi and will submit the manuscript to CMS for approval prior to publishing.

E. When project goals were not achieved, indicate what plans there are to complete the project after the award period, how project activities will be funded, and when they are likely to be completed.

Not applicable.

F. Describe the audiences for the project. Indicate the nature, size, geographic reach, sex and age of the audience and assess the impact that the project had on this audience.

The QualityImpact PTN reached 4,692 clinicians providing care to 2,128,447 patients located primarily within the Southeast. The PTN reached 735 practice sites across Alabama, Arizona, Connecticut, Florida, Georgia, Illinois, Louisiana, Mississippi, Missouri, North Carolina, Ohio, Pennsylvania, South Carolina, Tennessee, Texas, Virginia, and West Virginia. Representing 49 unique specialties, the QualityImpact PTN provided technical assistance to approximately 42 percent primary care providers and 58 percent specialty care providers. Amongst the diverse specialty types within the network, the most common include Obstetrics/Gynecology, Psychiatry, Cardiology, and Surgery. Of the 735 enrolled practices, 79% transitioned to value-based payment arrangements, demonstrating the PTN's substantial success in promoting APM readiness and clinical transformation.



The QualityImpact PTN served uniquely diverse and high-risk populations across the Southeastern US while remaining dedicated to providing patient-centered care solutions and advancing the health and well-being of the PTN's network of over 2.1 million patients. As demonstrated in Table 1.0, QualityImpact improved health outcomes across 195,136 of the 73,465 total committed patients with cardiovascular-related conditions, measured through high-impact processes and outcomes. Noteworthy results include the achievement of a 15 percent improvement in hypertension control across 524,221 patients, and a five percent improvement in diabetes care management across 103,486 patients.

G. What, if any, is the long-term impact of your project for improving health care?

Over the course of the TCPi demonstration, the QualityImpact PTN worked with practices to develop sustainable, patient-centered care solutions for lasting value-based care practices. PTN efforts largely focused on helping practice leaders and care teams to build a knowledge base around clinical transformation, providing them the tools for continued value-based care improvement. For example, the QualityImpact Champions' Network provides practices the opportunity to engage in peer-to-peer learning through the alumni portal and continue to share best practices and lessons learned in value-based care transitions. While the PTN's role as a catalyst for clinical transformation under TCPi is coming to a close, QualityImpact is confident it has developed an infrastructure for sustained results in close partnership with the alumni practices.

H. Please include a list of all publications associated with this project over the award period. [final publications should be uploaded into the Publications Portal by end of close-out)].

Guest Column; Health IT Outcomes, "Leveraging the Right Ruler for Measuring Clinical Outcomes". By Amy Amick, SPH Analytics: https://www.healthitoutcomes.com/doc/leveraging-the-right-ruler-for-measuring-clinical-outcomes-0001 [healthitoutcomes.com]

I. Please include a list of all supporting materials associated with this project over the award period. [Final supporting materials should be uploaded into the Publications Portal by end of close-out].

A comprehensive list of PTN supporting materials includes the following:

- 2017 Performance Improvement Sprint Template
- 2018 Clinical Action Program Template
- Getting Started Guides
    - Care Management
    - Annual Wellness Visit
    - Team-Based Care
    - Risk Stratification
    - Advanced Payer Contracting
    - Data-Driven Population Management
    - Access to Care
    - Business Acumen
- Medicare Wellness Visit (MWV) coding guide
- APM and MIPS Guides
    - APM Readiness Bootcamp Webinars
    - APM one pagers
    - APM and MIPS Guides
    - MIPS Flashcards
- Billing and Coding Webinars
    - Understanding E&M Guidelines: Getting Paid for What You Do
    - Medicare Wellness Visits
    - Chronic Care Management
    - Transitions of Care
    - Quality Measurement and Reporting
    - HCCs and Risk Applications
- Assessment Discussion Guide
- Marketing Toolkit
- Clinical treatment and management protocols (developed by the subcommittee)
- Small Practice Workshop Series
    - Series I: Optimizing Population Reporting to Succeed in QPP
        - Reducing the Reporting Burden
        - Selecting & Aligning on Performance Measures

        - Identifying Priority Populations & Assessing Opportunities for Improvement
    - Series II: Implementing Team Efficiencies to Create Capacity for Success
        - Workflow Mapping to Assess for Bottlenecks & Inefficiencies
        - Team-Based Roles and Responsibilities
        - Using Technology to Create Capacity
- QPP Readiness Series
    - MIPS Reporting Overview
    - Selecting Performance Measures
    - Integrating PFE Strategies to Accelerate Performance
- APM Bootcamp
- Controlled Substance Agreement (developed by the BH/SUD Sub-Committee)
- Sunsetting FAQ
- Sunsetting Resource Guide

The listed resources were uploaded in conjunction with this final report to the Publications Portal.

J. Indicate whether or not any subject inventions were made. If inventions were made, you must indicate whether or not they have been reported. Please indicate if invention information has been submitted via Invention Statement HHS 568 (subject inventions are inventions that were conceived for first actually reduced to practice during the course of the work funded by the award).

Not applicable.

Certification: *I certify to the best of my knowledge and belief that this report is correct and complete for performance of activities for the purposes set forth in the award documents.*

Authorized Organizational Representative:

Debra Simmons Digitally signed by Debra Simmons Date: 2019.12.16 13:31:20 -05'00'

Date:

December 16, 2019

Debra Simmons, MS, RN
Executive Director, COSEHC
QualityImpact Practice Transformation Network
336-716-1130 (o); 336-255-5064 (c)
dwirth@wakehealth.edu