JHN News

Spring 2017

Primary Care Sites Selected for CMS and State Innovation Projects

The first three months of 2017 have been very exciting for many JHN primary care sites. Twenty-five practice sites were selected to participate in the Comprehensive Primary Care Plus (CPC+) and/or the State Innovation Model (SIM) Patient Centered Medical Home (PCMH) Initiative. The foundation of both programs is to enhance care delivery, drive practice transformation to improve health outcomes and explore alternative payment models. In addition, both programs provide participating practices funding to support embedded care coordinators who will be working with patients across multiple health plans.

In 2017, the number of people eligible to work with a Care Coordinator is nearly 65,000—up from only 10,000 in 2016. To support this massive increase, the Care Coordination department has hired three new Care Coordinators (two registered nurses (RNs) and one Licensed Master Social Worker (LMSW)), and is actively recruiting additional qualified RNs and LMSWs for the role.

Providers participating in SIM and CPC+ electing to have JHN embedded Care Coordinators have been divided into regions. Each region will be supported by an RN and MSW Care Manager team. At this time, each region has at least one assigned Care Coordinator and "meet and greets" to introduce the Care Coordinators to the practices have commenced. The new Care Coordinators are currently involved in Care Coordinator specific trainings and working on developing knowledge of their role, SIM and CPC+ programs, supporting payers, and community resources.

Additionally, current JHN Care Coordinators have been supplementing skills and knowledge by attending multi-payer Complex Care Management training through Michigan Care Management Resource Center (MiCMRC). JCMR will finalize template training and required documentation for Care Management services and the various codes. The JHN Care Coordination department has also reached out to support and collaborate with practices electing to supply their own Care Managers, by inviting them to weekly case reviews, offering JCMR Care Management template support, and by sharing information and resources.

Jackson Health Network is excited to support these programs and the participating practices. Our team understands the value in the work necessary to improve health outcomes and taking steps towards becoming the healthiest network in the state. Thank you to each office for all the hard work to help us get there.

Diabetes Measures Update

The Board of Directors (BOD) approved a change to patient age for inclusion in diabetic and prediabetic metrics. An upper age of 75 years is now in place, for measures without previously established upper limits. There is no change in age for the following measures: DM HbA1c testing, DM HbA1c <7.0% and DM Use of Statin. Patients over the age of 75 years should receive treatment appropriate to their health status, but they will not be included in JHN monitoring and incentive.

Our vision:

We, the participants of the Jackson Health Network, will operate as a close partnership between Henry Ford Allegiance Health and affiliated physicians as a foundation for building an integrated system of health care delivery for the Jackson community and beyond.

Patient Satisfaction

Patient satisfaction is increasingly linked to quality scores and dollars earned. As a result, JHN must include patient experience as an important arm of the Triple Aim. As a network, JHN did not do well in meeting our 2016 goals for patient satisfaction. In collaboration with Press Ganey and Henry Ford Allegiance Health, JHN assists practices in collecting and reporting data. To improve response rates and overall scores, it is vital patients are encouraged to complete a survey if they receive one. JHN recommends that practice staff make patients aware they may receive a survey from Jackson Health Network and encourage completion.

Hospital based providers are measured using surveys specific to the care components they impact. All targets are consistent with the HFAH established targets.

- Hospitalist: HCAHPS – doctor communication and overall experience
- ED providers: EDPEC survey – doctor respect, listening, explaining and time
- Anesthesiologist: Outpatient Surgery CAHPS – courtesy and explanation of anesthesia staff
- CG-CAHPS measures the patient *experience*, an expansive proxy for quality that takes into account the following:
- Timely appointments
- Timely care (refills, callbacks, etc.)
- Your communication skills
- What your patient thinks about you
- What your patient thinks about your staff
- Your office running on schedule

Working with staff to set a positive tone for the office, being on-time, establishing processes that ensure patients know what to expect at the end of their visit, and being attentive during conversation impacts satisfaction as much as being able to provide medical advice and treatment.

Fee Schedules Now Available

Blue Care Network, Health Alliance Plan and Priority Health fee schedules have been posted to the JHN website and are available to full participating practice managers and providers. It is important to note, fee schedules are to be kept ***completely confidential*** and are not to be shared with anyone. Fee schedules are specific to the JHN contract and are different than what is shared on the payor websites.

To ensure accuracy, please always refer to your JHN contract specific fee schedules. If you are unable to access, please contact Brittany Easton, Provider Servicing Representative at Brittany.Easton@AllegianceHealth.org.

DEA Renewal

The Drug Enforcement Agency (DEA) recently released information regarding changes to the DEA license renewal process.

Key points include:

- Starting January 1, 2017, the DEA will only send out **1 renewal notification**, 65 days prior to your license expiration.
- If this deadline is missed, the online renewal will not be available, and the provider will have to reapply for a DEA license.
- There will be **no grace period** for renewal, after the renewal date has expired.

Please ensure that protocols are in place so this important deadline for renewal is not missed. As always, feel free to reach out to your JHN provider representative or visit DEADiversion.USDOJ.gov/DrugReg/Index to gain more information on this important announcement.

JHN Supporting the Transition to Epic

JHN leaders and staff have been actively involved in planning for the transition to Epic to ensure reporting capabilities are intact for the year. For member providers not on the Epic system, there will be a transition of the current Gateway to a tool within the Epic system. This template is still in development.

What we know:

- There are capabilities within Epic that are not available in NextGen—providing enhanced coordination of care.
- JHN Compass is being implemented within Epic as a bridge strategy for the remainder of 2017. Providers and office staff will use a combination of Epic Healthy Planet and Compass capabilities during 2017. JHN is continuing to work with the Epic install team to develop the most efficient work flows for your offices. Additional training will be provided by your JHN team closer to go-live and information concerning 2018 processes will be shared when available.
- Results of tests completed at an HFAH facility will auto-populate discretely in Epic. For example, manual entry will not be required for mammography done within the HFAH system.

Preparing for EPIC – Problem List

The problem list plays a more central role in the Epic EHR, where a single list is visible— for each patient—across all venues of care (ambulatory, emergency department and inpatient). Currently, Problem Lists are inconsistently utilized in NextGen because the JHN metrics have been driven primarily from ICD 10 billing codes. To prepare for this transition, JHN worked with the HFAH Epic team and MPM in establishing best practice for consistent use of the problem list prior to transition.

Providers are strongly encouraged to "clean-up" problem lists in NextGen as they see patients as the lists are being converted to Epic. Correcting the list prior to conversion will make the post go-live implementation smoother.

Why use the Problem List?

- The patient's problem list is **shared across the care continuum and multidisciplinary teams**.
- Patient problems are used for **clinical decision support,** such as recommended order sets and as triggers for best practice advisories (clinical alerts).
- Patient problems are used as **criteria for inclusion in chronic disease registries**. JHN clinical metric populations will utilize these chronic disease registries with the transition to Epic.
- The problem list will become an **integral part of documentation** and facilitate accurate coding, problem oriented charting in the inpatient setting and prompting capture of CMS Hierarchical Condition Codes that drive RAV scores (ambulatory case mix index).
- The problem list will be visible to patients in the **patient portal**.
- A snapshot of the problem list will be included in the **data conversion** from NextGen to Epic.

What should be included in the Problem List?

The following provides definitions that differentiate encounter diagnoses from patient problems.

Diagnosis This Visit	Problems Active Across Encounters
Diagnoses are associated with a particular patient encounter.	The problem list is associated with and linked to a patient and crosses encounters.
▪ Conditions that are the **reason for the patient's visit**, which may also appear on the patient's problem list. ▪ An **acute symptom** while under active evaluation for a diagnosis, e.g., headache or abdominal pain. Once a diagnosis has been made, it should be replaced on the Diagnosis List as a replacement for the symptom. ▪ **Acute minor problems** that will likely resolve by the next visit, e.g., URI, minor rash, strep throat. ▪ **Symptoms**, unless the symptom is chronic, and a diagnosis has not yet been made, e.g. "chest pain" should be replaced by "angina pectoris." ▪ **Conditions that develop during the course of the hospitalization** and require evaluation, treatment, monitoring, or increase the length of stay. ▪ **DO NOT include** resolved chronic problems or conditions from the patient's past medical history that are no longer under treatment or have no bearing on the current medical care.	▪ Conditions that **extend across encounters**, which are usually chronic (e.g., diabetes, hypertension). ▪ Any condition requiring the **ongoing** use of scheduled or ordered PRN **medications**. ▪ Medical conditions requiring **frequent laboratory testing** for monitoring purposes. ▪ Chronic medical conditions that require **continued treatment, screening or monitoring**. ▪ **Recurring acute** medical conditions requiring evaluation or treatment e.g., recurrent urinary tract infections. ▪ An **old problem** not requiring current treatment which **still influences current treatment** decisions for other problems, e.g. history of DVT. ▪ Active or relapsing **chemical dependency or abuse** (including tobacco). ▪ **Positive screening tests** that will have an impact on continuing care or disease risk. ▪ **DO NOT include** resolved chronic problems or conditions from the patient's past medical history that are no longer under treatment or have no bearing on the current medical care.