Best Practices in Managing Patients with Rheumatoid Arthritis

Advocate Medical Group

Standardizing Functional and Disease Activity Assessment Processes
Organizational Profile

Advocate Medical Group (AMG) is a physician-led medical group providing primary care, specialty services, medical imaging, and outpatient ancillary services in community-based medical practices throughout the northeastern and central Illinois service areas. AMG is part of Advocate Health Care, the largest health system in Illinois and one of the largest health care providers in the Midwest. Composed of more than 1,200 providers in 50 medical and surgical specialties, AMG provides care in more than 250 community-based medical practices and serves nearly 750,000 unique patients through approximately 2.5 million outpatient primary care, specialty, medical imaging, and ancillary outpatient encounters. The medical group carries some level of financial risk (partial to full) for nearly 125,000 patients in Commercial Managed Care or Medicare Advantage contractual relationships and participates in one of the nation’s largest Accountable Care Organizations. Lastly, AMG participates in a nationally leading quality improvement Clinical Integration program that boasts top decile performance in 27 National Committee for Quality Assurance (NCQA) benchmarks.

Established in 1980, AMG is committed to advancing Advocate Health Care’s goal of building lifelong relationships with patients by delivering the best health outcomes and highest level of service through an integrated approach to care and wellness. In particular, AMG is supported by eight rheumatologists that practice in six different locations and serve approximately 7,000 patients. All six practice sites and eight rheumatologists are integrated into the same EMR platform, Allscripts.

Project Summary

Because of AMG’s geographic diversity and rapid growth since 2010 from 600 to 1,300 providers, the rheumatology practices were not integrated into a single program at the start of the Collaborative. The rheumatologists were each practicing with limited cooperation around workflows or process standardization with other rheumatologists across the medical group. The Collaborative was one of the initial steps to bring the rheumatology practices together to create opportunities for teamwork and consistency. The goal of the Collaborative was to bring the rheumatology practices together in an effort to standardize the collection of functional and disease activity assessment processes.

At the completion of the Collaborative, the team had standardized workflows that captured these functional and disease activity assessments and successfully piloted them into two rheumatology practice sites, with roll-out for the remaining four practice sites still in process. The greatest accomplishment was that by the completion of the Collaborative, all eight rheumatologists and their practice leaders had met twice during the course of the year and begun creating the culture of a single rheumatology program rather than separate rheumatology practices within a medical group.

Program Goals and Measures of Success

Goals and Objectives / Clinical Standards

At the start of the Collaborative, the organization was tracking the Physician Quality Reporting System (PQRS) 108 STARs metric (DMARD use) within the Medicare Advantage population and several other quality metrics (i.e., flu vaccination, generic prescribing, etc.) through the organization’s Clinical Integration program. The only
metrics visible directly to the rheumatologist were their own specific Clinical Integration quality improvement metrics and other payer-reported metrics, which were tracked at the organizational level only.

AMG was performing at 3 stars for the PQRS 108 measure of the Medicare Advantage population. However, the organization had no data regarding the performance of the PQRS 177 (assessment of disease activity) or the PQRS 178 (assessment of functional status) measures. Physicians had no defined way to capture the disease and functional activity assessments associated with these measures within the EMR. Physicians were completing these assessments, but were documenting them in various, non-discrete methods (i.e., scanning the assessments into the encounter, documenting the results in the body of chart notes, etc.). As such, the performance of these measures at baseline was unknown.

The project team identified the following goals:

1. Create a single point of reference for rheumatologists to easily, visually, and longitudinally review the functional and disease activity assessments, key labs and preventive care services.

2. Standardize the process for capturing the functional and disease assessments (who, when, where, and how).

Data Collection and Measurement

The project team worked closely with the EMR and analytics teams to create the workflows that would capture the results of the functional and disease activity assessments. The team discovered that the easiest way to identify and display this information would be through existing flowsheet technology within the EMR. Flowsheets provide concise, visual, and longitudinal displays of a diverse array of information. In addition, flowsheets are used to facilitate the capture and reporting of numerous other chronic disease-related quality metrics, and as such represented the ideal solution.

The team adopted the measurement specifications as defined by the Collaborative workgroup. The RAPID3 and MDHAQ functional and disease activity assessments were selected for pilot purposes.

Outcomes and Results

Goal 1: Create a single point of reference for rheumatologists to easily, visually, and longitudinally review the functional and disease activity assessments, key labs and preventive care services.

In collaboration with the EMR team and rheumatologists from the various practice sites, the project team selected the specific components and design of the flowsheet by December 1, 2014. The flowsheet was then built and deployed into the production environment by February 1, 2015. See Figure 1 for sample screenshot of the flowsheet.

Goal 2: Standardize the process for capturing the functional and disease assessments (who, when, where, and how).

Four different workflows were piloted to identify the most efficient and most successful method of capturing the functional and disease activity assessments. The workflows include:

- Mailing the assessments to patients for completion at home to bring to the office for input into flowsheets.
- Having office staff (i.e., certified medical assistants, care managers, etc.) telephone patients prior to their visit to complete and record the assessments.
- Utilizing the centralized call center for outbound telephone outreach to patients prior to the visit.
- Capturing of the assessments at the time of visit without any pre-visit outreach.

The results of the workflow pilots identified that pre-visit mailings and office-based captures were the most efficient and successful methods for obtaining the functional and disease activity assessments (see results in Figure 2). These two workflows were continued through Q3 of 2015 in the pilot sites and rolled out to the remaining rheumatology practice sites beginning October 2015 after the completion of the Collaborative.

By the end of the Collaborative, 23.5% of all patients seen within AMG rheumatology practices had documented functional and disease activity assessments. However, this number is misleading as the workflows were only rolled out in two of the six practice sites. When looking only at the two
pilot sites, 80% of patients seen during the Collaborative 5 reporting period (10/1/2014 – 9/30/2015) had completed the functional and disease activity assessments. Lastly, while not a direct focus of the project, the organization continued to perform well on the PQRS 108 DMARD use measure (see Figure 3).

Population Identification

Prior to applying to participate in the Collaborative, AMG performed a review of EMR-based claims data of the eight rheumatologists practicing within the six rheumatology practice sites. The data identified 13,852 office visits for 6,695 patients (5,166 female, 1,529 male) treated in rheumatology. Of these patients, 2,083 had a diagnosis of RA (714.XX) active on their “problem list.” These patients accounted for 30% of patients who visited the rheumatology department and yet disproportionately accounted for 41% of all rheumatology visits (5,641 visits) and ancillary resource utilization (radiology, labs, vaccines, infusions, injections, etc.).

For subsequent reporting, we relied on the AMGF RA Collaborative Measurement Specifications, which further narrowed the intervention population to between 900 and 1,300 patients, depending on the reporting period.

Intervention

At the initiation of the Collaborative, a project team was convened that included two rheumatologists from two practices in different regions, their operations directors, practice managers, and staff members, along with representatives from the Quality Improvement Department, pharmacy leadership, and ad hoc experts from IT, EMR, and analytics.

The team discussed the Collaborative project scope, defined its current state, articulated ideal state attributes, and identified several gaps and barriers to accomplishing the ideal state. In
Denominator includes patients from all eight practice sites, but numerator only includes results from the two pilot sites that participated in the capture of the disease activity assessments and functional activity assessments.

Because of technical difficulties in the meds list query, Baseline and Periods 1, 2 and 3 results do not include those products that were not physically prescribed but that were added to the current meds list (i.e., infusion products, or DMARDs ordered by non-AMG providers but that were added to the meds list) during the reporting period. The issue was rectified during reporting periods 4 and 5. Because of this, Baseline and Periods 1, 2, and 3 are artificially lower because they exclude meds added on current meds list that were not prescribed via an order such as infused medications, or DMARDs ordered by non-AMG rheumatologists.
particular, the current state did not allow for formal capture of functional or disease activity assessments in the EMR. Each physician had “their own way” of capturing and storing this information for the purpose of delivering care.

Based on the articulated ideal state core attributes, the team agreed that any solution should include a concise, visual (easy to interpret), and longitudinal (scores over time) summary of both assessments. The team also agreed that as part of the capture and display of the functional and disease activity assessments, the developed tool should display key labs (i.e., C-reactive Protein, Erythrocyte Sedimentation Rate) and preventive care needs (i.e., vaccinations, screenings, etc.) so that the physician had one place to look to review patient progress over time.

After spending time with the EMR team, it was agreed upon that the easiest way to display this information would be through existing flowsheet technology within the EMR. Flowsheets can provide concise, visual, and longitudinal displays of a diverse array of information. In addition, flowsheets are used by the organization to facilitate the capture and reporting of numerous chronic disease-related quality metrics.

The team identified that the biggest barrier to using a flowsheet for displaying functional and disease activity assessments was the capture of results of the assessments discretely. For discrete data such as labs, this is relatively easy; however, for patient self-reported items that are scored outside of the EMR (i.e., these assessments) the process is manual. The team noted that the opportunity for the organization is not where the results of the assessments will be stored, but rather how, when, and by whom the information will be captured. Four workflows (noted above) were developed that may facilitate the capture of the functional and disease activity assessments. The team agreed that these workflows would be trialed as a pilot in two of the six rheumatology practices. Based on the results of the trials, the team will expand the best workflow(s) to the remaining four practice sites and rheumatologists. The team created a timeline to trial each of these methods for the two designated pilot sites. The EMR team and analytics teams created a report that was delivered daily to the project team. The report identified patients on the schedule who had a previous RA claim or who had RA listed on their problem list. The report was used to generate the daily patient lists for the workflow trials.

The project team utilized a simple Excel spreadsheet to track the following parameters on each of the trials:

- Patient Demographics
- Number of Attempts to Reach the Patient (for call-based outreach)
- Total Process Time
- Capture of Assessment Success Rate

Staff at the sites and the call center were educated by the project team on the RAPID 3, all workflows and the Excel tracking spreadsheet. Local operations managers reported to the project team weekly on the status of each workflow trial. Workflow trials lasted between two weeks and four weeks.

**Leadership Involvement & Support**

Prior to applying for the Collaborative, support for the project was obtained by the Chief Medical Officer throughout C-Suite. A small project team (pharmacy, rheumatology, and quality improvement leadership) was convened by the C-Suite to conceive of the project design and to apply to participate in the Collaborative. Once awarded the opportunity to participate in the Collaborative, a larger project team was convened and EMR leadership, IT Leadership, and regional operations vice presidents, directors, and managers were engaged in the project. Operations vice presidents and medical management supported the project team through a steering committee-like structure. The project was led by two regional operations directors and pharmacy leadership.

**Lessons Learned and Ongoing Activities**

The project team reflected frequently throughout the Collaborative and at the completion of the Collaborative and identified several opportunities and lessons learned.

- Engaging and scheduling resources (i.e., EMR team and analysts) early on can help support teams plan more appropriately and prevent delays from other competing organizational priorities (i.e., EMR upgrades). Several delays to our project were encountered because we did
not engage these teams early enough. The resource restrictions delayed the build of the flowsheet. This further delayed initiation of the workflow trials in the pilot sites and subsequently delayed the ability to roll out the selected successful workflows to the remaining rheumatology practice sites. Engaging critical support resources earlier in projects can help prevent future delays.

- We may have trialed some of the interventions longer than we needed. For example, it was clear early on that the outbound calling workflows were only marginally successful. To stay true to the project plan, we continued the trials although we could have saved two to four weeks had we cut those trials early. Our lesson learned was that being flexible and stopping trials sooner than anticipated may help in buying back time that was lost during previous delays.

- We did not expect the mailing workflow to be very successful, but it was nearly 100% effective. It is worth trialing interventions that may help even if you don’t think they will be successful.

- The team committed early on to weekly accountability calls. These calls were short (15 minutes) but helped keep the team on track.

**Acronym Legend**

- CDAI: Clinical Disease Activity Index
- DMARD: Disease-Modifying Anti-Rheumatic Drug
- HAQ: Health Assessment Questionnaire
- MDHAQ: Multi-Dimensional Health Assessment Questionnaire
- PQRS: Physician Quality Reporting System
- RAPID 3: Routine Assessment of Patient Index Data 3
- SDAI: Simple Disease Activity Index
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