AMGA

Advancing High Performance Health

AMGA Foundation

Best Practices in Managing Patients with Rheumatoid Arthritis

USMD Health System

Reducing Variation and Engaging Specialists

Organizational Profile

USMD Health System (USMD), a multispecialty medical group, provides primary and specialty care to more than 450,000 patients annually across the Dallas-Fort Worth, Texas, area. The system is a large, integrated care organization that encompasses two acute care hospitals, 26 primary care medical centers, 20 specialty centers and four cancer treatment centers.

The health system has 1,964 employees, including 250 providers (133 primary care providers and 117 specialists) and 55 advanced practice clinicians (nurse practitioners, physician assistants, etc.). USMD has 10 rheumatology providers who serve six sites around the metro area. It also uses NextGen as its EMR in the primary care and rheumatology divisions.

In 2014, the organization provided one million patient encounters, of which 17% were conducted through the medium of "virtual medicine" (secured messaging between physician and patient).

The mission and vision of USMD Health System stems back to 1992, when a single-specialty surgical group began to collaborate on excellence in patient outcomes (outcomes that would receive national recognition for the group before the close of the decade). The hallmark of superior specialty health care is an interdisciplinary collegiality with primary care. The premier primary care medical group in the area included a variety of specialty group partnerships across the region. The collegiality of these two groups led to the single surgical-specialty group joining forces with the premier primary care physician group in 2012 in a merger that would absorb two physician-owned hospitals. The Triple Aim mission of USMD is thus firmly rooted in a history defined by premier physicians who collaborate across specialties because they have a common vision of superior patient outcomes throughout a continuum of care.

Project Summary

USMD took on this rheumatoid arthritis (RA) project because the organization felt the Collaborative aligned well with its core value of putting "Patients First," as well as the parts of its Triple Aim mission that focus on "Better Care" and "Better Health." The clinical metrics for this project involved the three PQRS measures: DMARD usage, functional status measurement, and disease activity tool usage. USMD had the benefit of having adopted clinical metrics into its culture for all of its physicians (including medical specialists) for several years, and the DMARD metric was one that its Rheumatology Department had already chosen to focus on prior to this initiative. As a result, USMD decided to focus mainly on the functional status and the disease activity severity metrics as the main thrust of its project. It also used this opportunity to reduce variation across the organization in regards to RA care and to engage its specialists further down the quality path that its primary care physicians have been on for the past decade.

USMD saw swift engagement from its IT team to install the needed EMR templates and conduct trainings. Overall, the health system's rheumatologists embraced the project and created new workflows for their teams to incorporate the information in a meaningful way. They also took it as an opportunity to provide additional RA-specific training to staff. USMD went from 0% measured usage to 68% in one year for the functional status and disease activity assessments (using the MDHAQ and the RAPID 3 combined tool), while maintaining its 98% DMARD usage rate.

The USMD rheumatology team leaders led by example and served as the champions for the project. The group regularly shared the data with each of the rheumatologists, as well as with the organization's leadership, who fully supported the efforts. The organization was also able to do some focused training for primary care providers as a result of this project,

standardizing its patient education for RA. Overall, USMD was very proud of its first Collaborative effort involving medical specialists and has learned a tremendous amount that it can use as a blueprint for future projects in order to improve the health of the communities we serve.

Program Goals and Measures of Success

Goals and Objectives

The goals and objectives of the program included implementing the MDHAQ Functional Status/RAPID3 Assessment Tool electronically into the EMR system, increasing utilization of the MDHAQ Functional Status/RAPID3 Assessment Tool in the rheumatology practice, implementing a program to increase awareness of and use of care guidelines for RA for primary care providers, standardizing patient education materials to support management of RA, identifying disparities in care for the RA population and developing action plans to address these disparities, and continuing to track DMARD use in RA and maintaining a high level of success.

In terms of clinical standards, USMD used the American College of Rheumatology (ACR) PQRS standards of DMARD usage and MDHAQ/RAPID 3. To reference data collection and measurement, see Table 1.

Goal #1: Increase assessment of RA patients via the MDHAQ and RAPID 3 Tools.

USMD's plan was to increase utilization of the tools across all providers in 25% increments each quarter, with the goal of achieving 100% utilization by Q3 2015 (see results in Table 1). USMD did not achieve as high a result as it set out to do, but feel they made significant progress as a whole by bringing in the patients' self-assessment of their disease process into the formal workflow of the RA visit. USMD also felt it was able to get significant physician and staff buy-in into the process overall.

Goal #2: Continue tracking and maintaining scores on DMARD usage

USMD accomplished its goal of maintaining its percentage in the 98% range during this collaborative.

Goal #3: Look for disparities in care in the RA population and develop action plans to address any disparities identified

August 2015 Outcome: USMD's team focused on its MA patients, both Medicare and Medicare/Medicaid duel eligible patients. It was able to bring more focus, education, and a support system around RA patients. USMD did a deep-dive chart review for every patient in that program and assisted them in medication adherence with a pharmacy program and case management, as needed.

Table 1: Tool and Measurement Utilization

Reporting Period		Measure 1 – DMARD Therapy			Measure 2 – Disease Activity Assessment			Measure 3 – Functional Status Assessment		
		Denominator	Numerator	Percentage	Denominator	Numerator	Percentage	Denominator	Numerator	Percentage
Baseline	2014 Q2 (07/01/2013 – 06/30/2014)	2,406	2,370	98.5%	2,406	0	0.0%	2,406	0	0.0%
Collaborative 1	2014 Q3 (10/01/2013 – 09/30/2014)	2,440	2,399	98.3%	2,440	1,061	43.5%	2,440	1,063	43.6%
Collaborative 2	2014 Q4 (01/01/2014 – 12/31/2014)	2,499	2,461	98.5%	2,499	1,505	60.2%	2,499	1,506	60.3%
Collaborative 3	2015 Q1 (04/01/2014 – 03/31/2015)	2,544	2,508	98.6%	2,544	1,685	66.2%	2,544	1,686	66.3%
Collaborative 4	2015 Q2 (07/01/2014 – 06/30/2015)	2,618	2,570	98.2%	2,618	1,778	67.9%	2,618	1,779	68.0%
Collaborative 5	2015 Q3 (10/01/2014 – 09/30/2015)			0.0%			0.0%	0		0.0%

Goal #4: Develop an educational program for primary care providers to aid in early diagnosis of RA

August 2015 Outcome: USMD gave primary care providers educational seminars on RA and discussed proper diagnosis/testing, treatment protocols, and the importance of appropriate rheumatology referrals and DMARD usage.

Goal #5: Engage/educate primary care population by January 2015 and track outcomes for early RA diagnosing to estimate effectiveness

August 2015 Outcome: USMD put this component on hold and is awaiting the data analytics vendor's completion of its cohort management tool to continue monitoring this population closer. Currently, USMD only tracked DMARD usage on its MA patients for those who aren't followed by its rheumatologists.

For this project, USMD focused on the RA patients that were attributed to its rheumatologists (patients belonged to primary care physicians within and outside of the organization).

Goal #6: Develop patient educational materials to increase self-management of Rheumatoid Arthritis.

August 2015 Outcome: USMD has a new, updated patient education materials system—which includes multimedia tools—that went into the EMR in August. The rheumatologists also met and reviewed all the available materials found in various clinics and decided upon a more standard approach to RA handouts.

Goal #7: Complete development of patient materials and have them ready for patient distribution during RA Awareness Month, May 2015.

August 2015 Outcome: USMD decided to defer this goal to 2016. The organization is awaiting the data analytics vendor's completion of a new module to be able to pull the data to identify all of its patients with RA (not just those that see our rheumatologists. Also, it had a focus in May 2015 on Hypertension Education Month (USMD participated in the Measure Up, Pressure Down® initiative) and resources were diverted for that project this year.

Population Identification

USMD has 10 rheumatologists that provide care at six sites. USMD defines its RA population by looking in its EMR for the ICD 9 (now ICD 10) code of an RA diagnosis for patients who are 18 years or older and who were seen by its rheumatologists more than once in the last 12 months.

USMD added new templates specific for rheumatology into the rheumatologists' work flow, including the RAPID 3 and joint exams to make documenting and viewing easier and more efficient, and to decrease the number of "clicks," decreasing the need for changing screens as often. USMD also placed the scores for the RAPID 3 in a grid allowing them to be viewed over time so that the patient's disease severity can be more easily tracked and therapy can be escalated quickly if a decline is noted.

Intervention

Background

Before the project began, USMD had a 50-50 split in terms of engagement from its RA providers on using any kind of formal screening tools for functional assessment and disease activity, and no agreement in terms of which tool to use within in the organization. The organization had just completed installing the "rheumatology complete" template in the EMR to make documentation easier for rheumatologists, but had no discrete template to capture the RAPID 3 data and view it readily over time. DMARD usage among RA patients was appropriate and meeting targeted thresholds at start of this collaborative. However, USMD had a lack of consistency in the type of patient educational materials that were used across the organization. The medical specialists had never engaged in a formal collaborative prior to the RA Collaborative. Only the organization's primary care providers had done so.

Program Modifications

USMD engaged IT to create templates to generate and view the screening tools being measured. It focused on engaging the providers, site managers, and clinical support staff. USMD also developed workflow changes to implement the RAPID 3 screening in all patient workflows and monitored it for utilization.

Monitor Patients

USMD continued to collect data quarterly on all three quality markers for RA patients. The group maintained its already high performance on the use of DMARD in RA treatment. It also reviewed all MA RA patients and made sure the diagnosis was correct and, if not truly present, created a pathway to get that data back to the Centers for Medicare and Medicaid Services (CMS) for correction. Finally, USMD made formal referrals to care management for all MA dual-eligible patients, including those with RA, to ensure they had no barriers to care, including DMARD usage.

Staff Education

Education started at the provider level, with both rheumatologists and primary care providers. Clinical education included information on RA as well as education on the importance of the RAPID 3 screening and DMARD indications.

Workflow and Staffing Changes/Modifications

USMD increased front-line staff awareness of the RAPID 3 assessment tools and developed workflows to incorporate into all patient visits.

Information Technology

USMD implemented the MDHAQ Functional Status/RAPID 3 Assessment Tool electronically into its EMR system enhancing the ability to follow the disease activity easily over time. USMD also standardized patient education materials to support management of RA directly into its EMR for provider access at the point of care. The organization used data analytics to identify disparities in care for its RA population and develop action plans to address these disparities.

Leadership Involvement & Support

The leadership team was very supportive of the work done for the AMGA RA Collaborative. Leadership supported the team's time for travel and investment of analytics in the processes. They also allowed the team to promote this effort in its *Physician Weekly* e-letter, provider newsletter, and face-to-face meetings. They supported efforts to train providers in RA by allowing template development time to be allocated swiftly to support the team's data collection work. The team was encouraged to report its efforts to the Chief Executive Officer and Chief Physician Officer regularly and in front of the leadership team.

Lessons Learned and Ongoing Activities

A number of valuable lessons were learned throughout this process. Lessons learned included the fact that pharmacy and medication adherence are vital to a successful RA program and that USMD needs to increase pharmacy support across the group. Identifying RA patients early is key to achieving optimal health outcomes for patients. Developing and engaging primary care and rheumatology providers and staff also is vital to the success of the RA program. Swift IT changes and data analytics are crucial to being able to manage populations and to place vitally needed clinical information within the provider's workflow. Transparent clinical metrics are useful in driving change and in bringing attention to specific changes in clinical practice.

If USMD could have done something differently, it would have engaged the site manager, staff, primary care providers, and rheumatologists earlier in the process and incorporated more case management efforts, which could make an impact on the special needs of the patients who could not afford DMARD medication.

USMD did face a few challenges throughout this process, including engaging the last few rheumatologists who weren't involved with the initial Collaborative to increase assessments using the tools to capture the patients' perspective, as well as the physical exam and lab data. Another challenge was generating interest among primary care physicians in proper RA diagnosis and care guidelines—primary care providers have so many competing interests with diabetes, COPD, CHF, etc., it can be overwhelming for them. In addition, a lack of resources specifically dedicated to RA patients and no formal internal care guidelines or pathways for RA within the organization presented a challenge, as did finding ways to generate patient engagement and self-activation

(both specialists' patients and those in primary care base, i.e., internal and external patients to USMD's Patient Centered Medical Home) and addressing disparities from socioeconomic and age-related categories, especially in the elderly population where Medicare coverage of biologics is a problem.

Next Steps

USMD will continue to work on provider engagement, encouraging use of the assessment tools for those late adopters in the group. USMD plans to add the two assessment metrics (i.e., RAPID 3 usage) to its quality bonus plan in the future and add transparency around those metrics. USMD's other metrics are transparent to everyone in the organization; however, it had not begun that process with the new collaborative metrics.

USMD will continue to expand disparities research and address issues found in its RA patient population. The team will also pursue ongoing primary care education and to create a more refined referral process.

USMD has targeted May 2016 for its RA Awareness campaign. It has involved its marketing team to assist.

USMD's quality team plans on holding follow-up meetings the year after the Collaborative to see what other gains it can sustain from this work and identify what other areas in which it can apply its learnings.

The group will also standardize RA clinical guidelines internally and create easy-to-access labs and medication help within the EMR.

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

RA Team

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