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SNAPCAP
Safety Net Association of Primary Care Affiliated Providers of WNY

Experience Matters!

Innovative Quality Improvement for Vulnerable Populations

Evergreen Health Services
Help for Today. Hope for Tomorrow

May15, 2015

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Learning Objectives

Participants attending this presentation will be able to:

- Identify the foundational elements from PCMH and MU that enable successful population health management
- Learn to identify high-risk patients by stratifying your population using social determinants of health
- Describe at least two key interventions that can be taken to engage community resources to improve targeted outcomes
- Perform an organizational self-assessment of your readiness to effectively manage vulnerable populations and demonstrate improved outcomes

WELCOME AND INTRODUCTIONS

CTG Team Introductions

Jeanette Ball, RN, BSN, PCMH CCE
Principal Consultant

- >28 years of healthcare experience, with >10 years in ambulatory administration and >8 years in HIT
- Expertise: HIE development; EHR implementation; practice workflow efficiencies; NCQA Certified Patient- Centered Medical Home Content Expert
- Previously: Medical Center Administrator, large medical group and ambulatory health center; Senior Consultant, Community EMR Implementation; Experienced RN

Sarah Gardner, Associate Vice President
The Evergreen Association of Western NY

- Facilitator, Safety Net Association of Primary Care Affiliated Providers (SNAPCAP)
- Distinguished speaker on collaborative care for high-risk and high-need patients
- Former principal of EquiHealth Stategies, LLC; Director of Health Engagement and Business Development, P^2 Collaborative of Western New York; Vice President of Benefits and Employee Relations, Prodigy Healthy Group; and Senior Consultant, Aetna
- Featured in USA Today and CFO Magazine

Organization Associations

- DSRIP is the main mechanism by which New York State will fundamentally restructure the health care delivery system by reinvesting in the Medicaid program, with the primary goal of reducing avoidable hospital use by 25% over 5 years

SNAPCAP
Safety Net Association of Primary Care Affiliated Providers of WNY

- Safety Net Association of Primary Care Affiliated Providers (*SNAPCAP*) serves as an advocate for its members in *Western New York*

Evergreen Health Services
Help for Today. Hope for Tomorrow

- EHS has dedicated over thirty years to fostering healthy communities in WNY, offering a diverse range of medical, supportive and behavioral services

Evergreen Health Services

Mission Statement

- We foster healthy communities by providing medical, supportive and behavioral services to individuals and families in Western New York, especially those in marginalized populations and/or challenged by chronic or life-threatening diseases

BUILDING THE FOUNDATION

Feeling Adrift in Seas of Change?

DSRIP

Quality

ICD-10

MU Stage 1

System Upgrades

MU Stage 2

PQRS

PCMH

Patient Portal

BI Strategy

Population Health

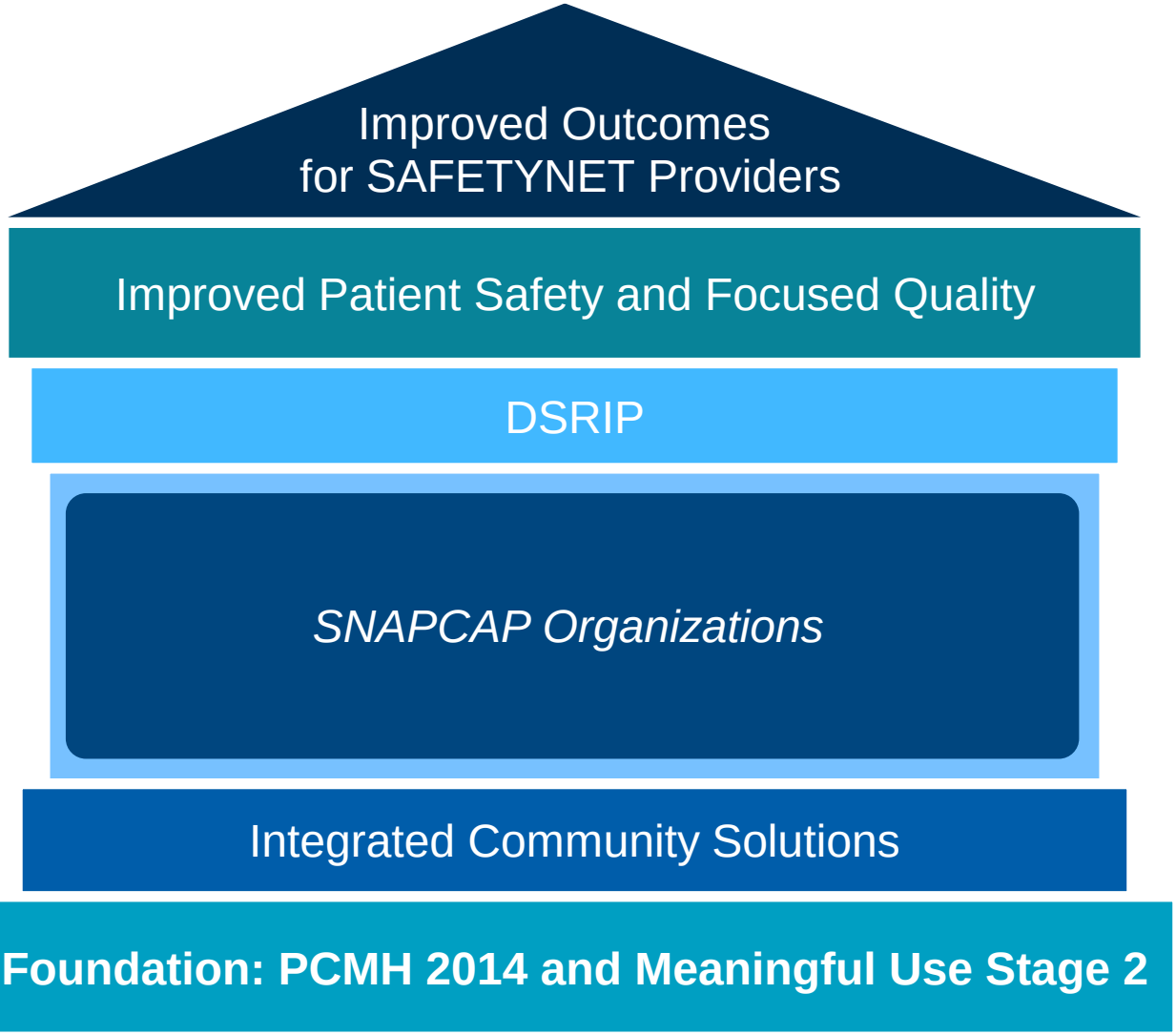
Shared Care Plan

Connectivity

Leveraging PCMH and MU as Foundations

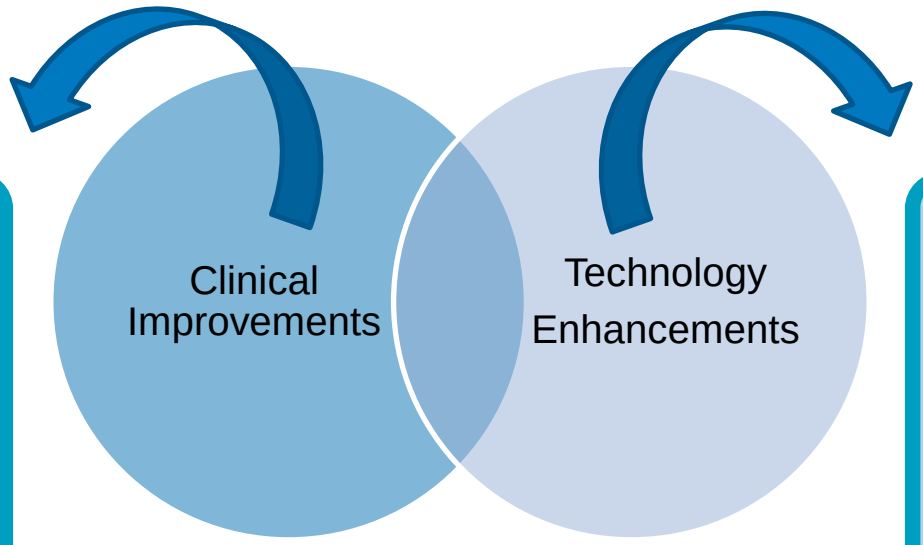
DSRIP and SNAPCAP

- Key Foundational Elements for SAFETYNET Provider Success



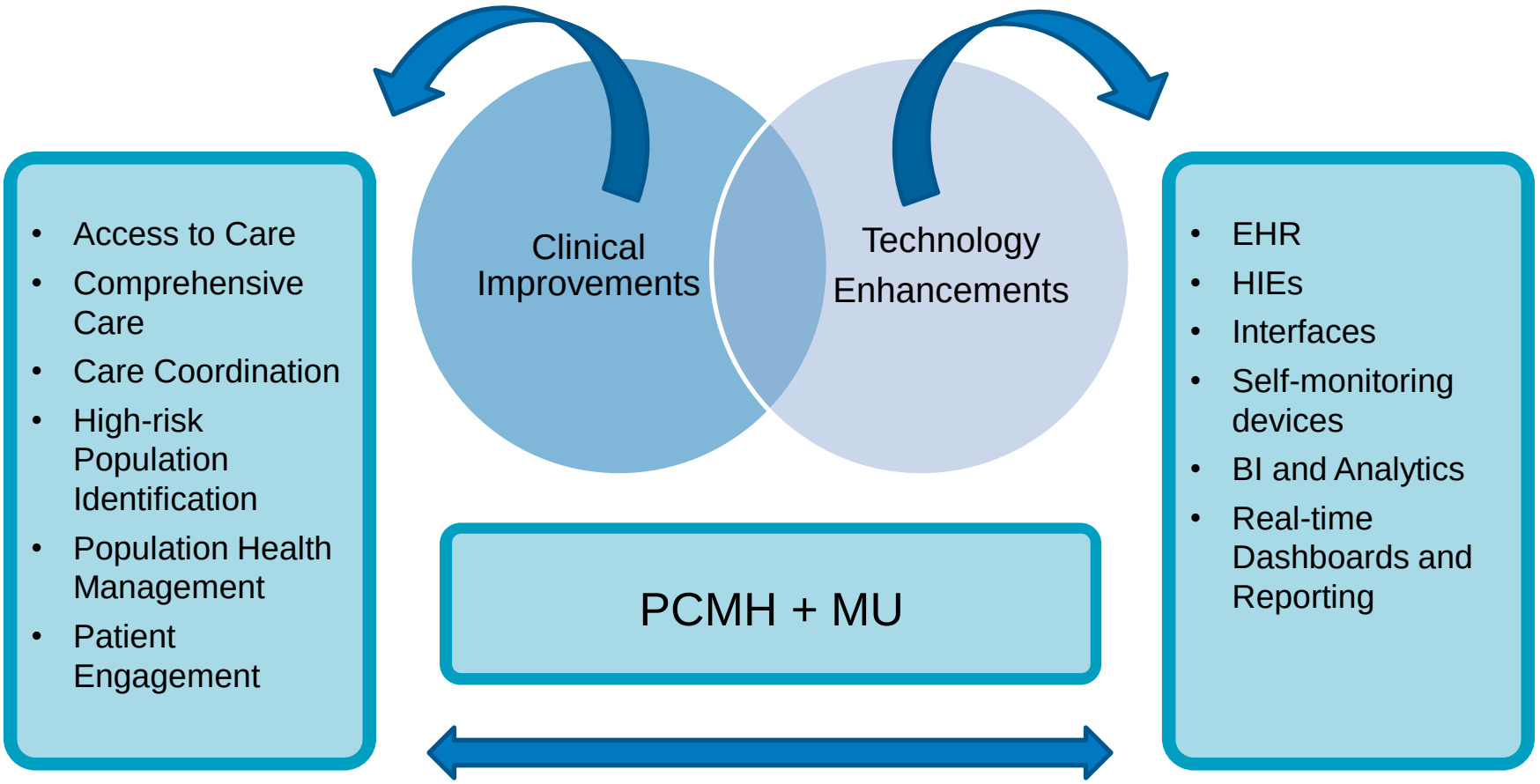
A Marriage of Two Initiatives

- Access to Care
- Comprehensive Care
- Care Coordination
- High-risk Population Identification
- Population Health Management
- Patient Engagement



- EHR
- HIEs
- Interfaces
- Self-monitoring devices
- BI and Analytics
- Real-time Dashboards and Reporting

A Marriage of Two Initiatives



The building blocks for PCMH and MU help establish the foundation for bridging these two initiatives

Using Technology for Clinical Improvement

PCMH and MU bring the following building blocks to organizations…

PCMH

- Patient-centered Access
- Team-based Care
- Population Health Management
- Care Management and Support
- Care Coordination and Care Transitions
- Performance Measurement and Quality Improvement

MU

- Advanced Clinical Processes
- Discrete and Structured Data
- Coordination of Care across Continuums
- Patient Portal and Engagement
- Exchange of Information
- Electronic Performance Submissions
- Cross-continuum Care Processes

The Key to Functionality: Interoperability

HEALTHeLINK, the Western New York HIE, was created with the following goals:

- Improving Clinical Interoperability through out the community
- Optimize the use of technology for chronic disease management through the HIE
- Decrease redundant unnecessary testing
- Point of Care access to up to date patient information
- Increase the number of PCMH-modeled practices to improve primary care

Health Information Exchange (HIE)—"The Noun"

15

HEALTHeLINK Progress

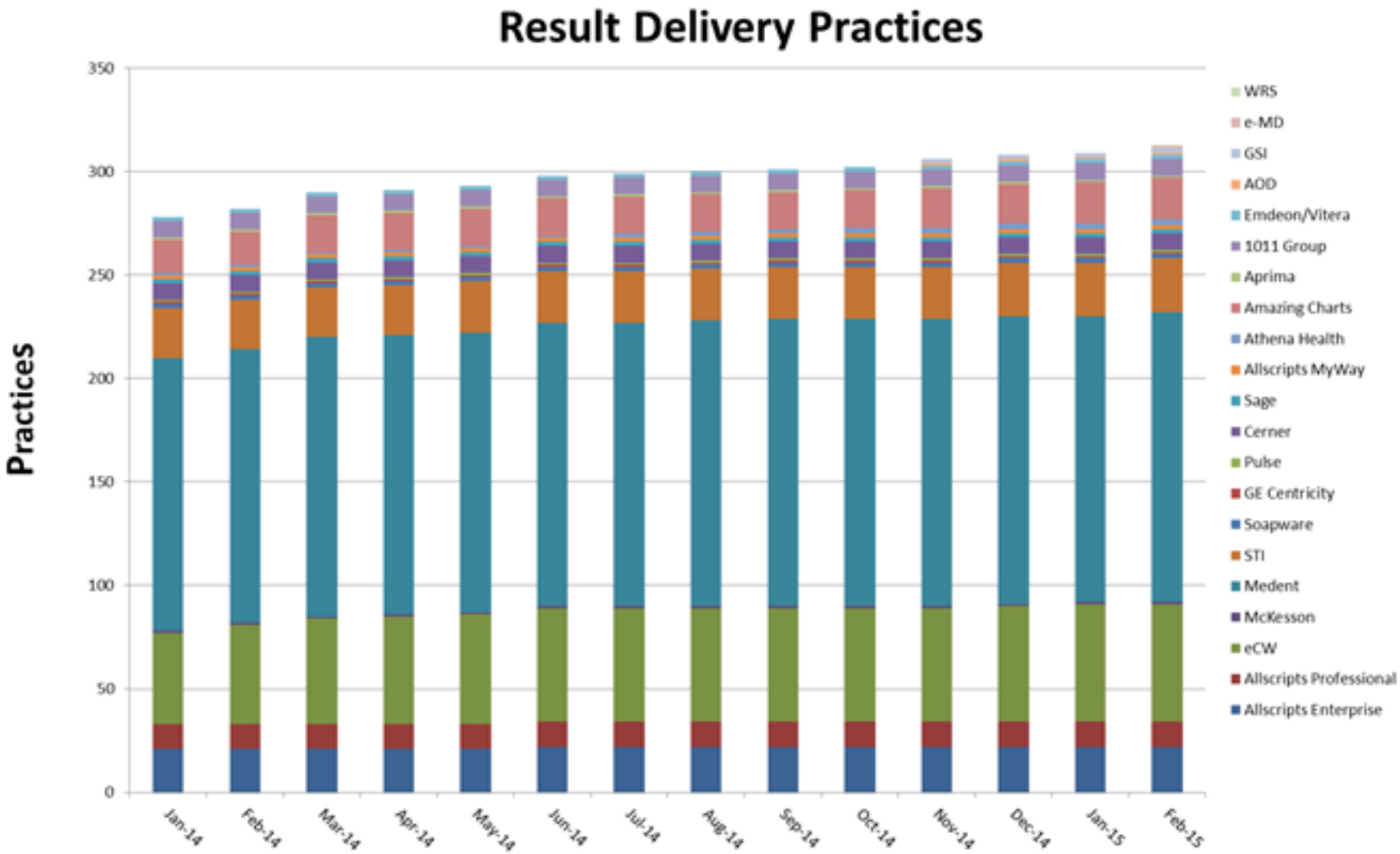
Success

- 700,000 patient consents
- 21 direct vendor interfaces
- All hospitals in the Western New York region
- Quest Diagnostics
- Home care monitoring
- Medical Home alerts

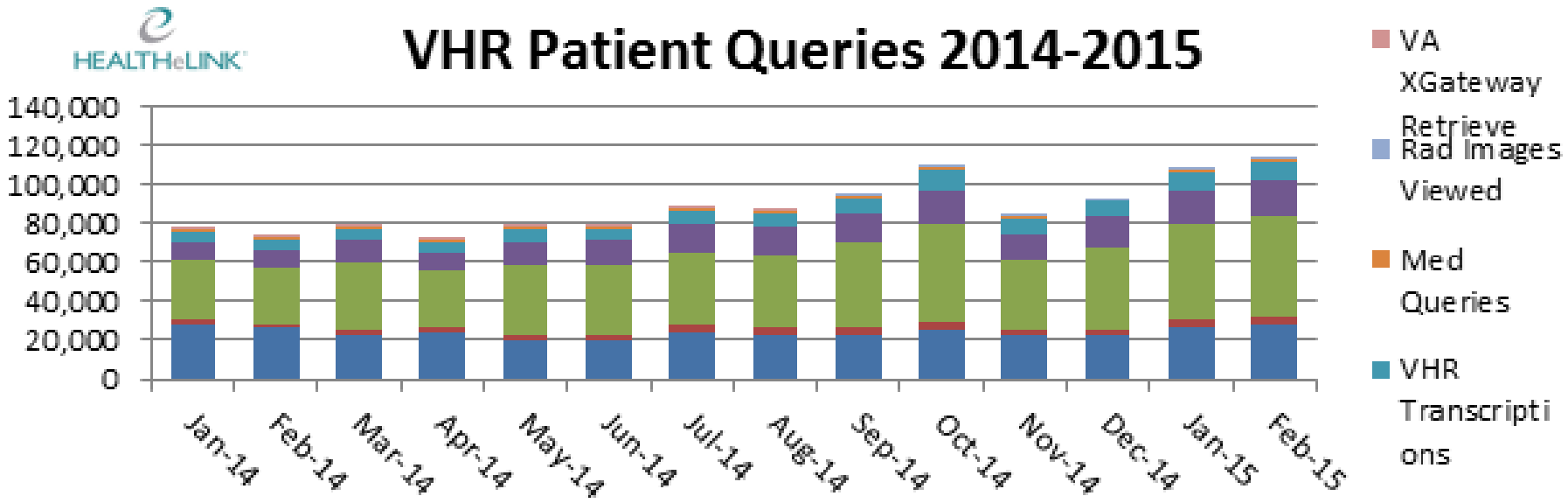
Challenges

- Not accessible in EMR directly
- HL7 data inconsistent
- Normalizing CCD data
- Data analytics
- State connections to Medicaid

Connecting a Community



Finding the Answers



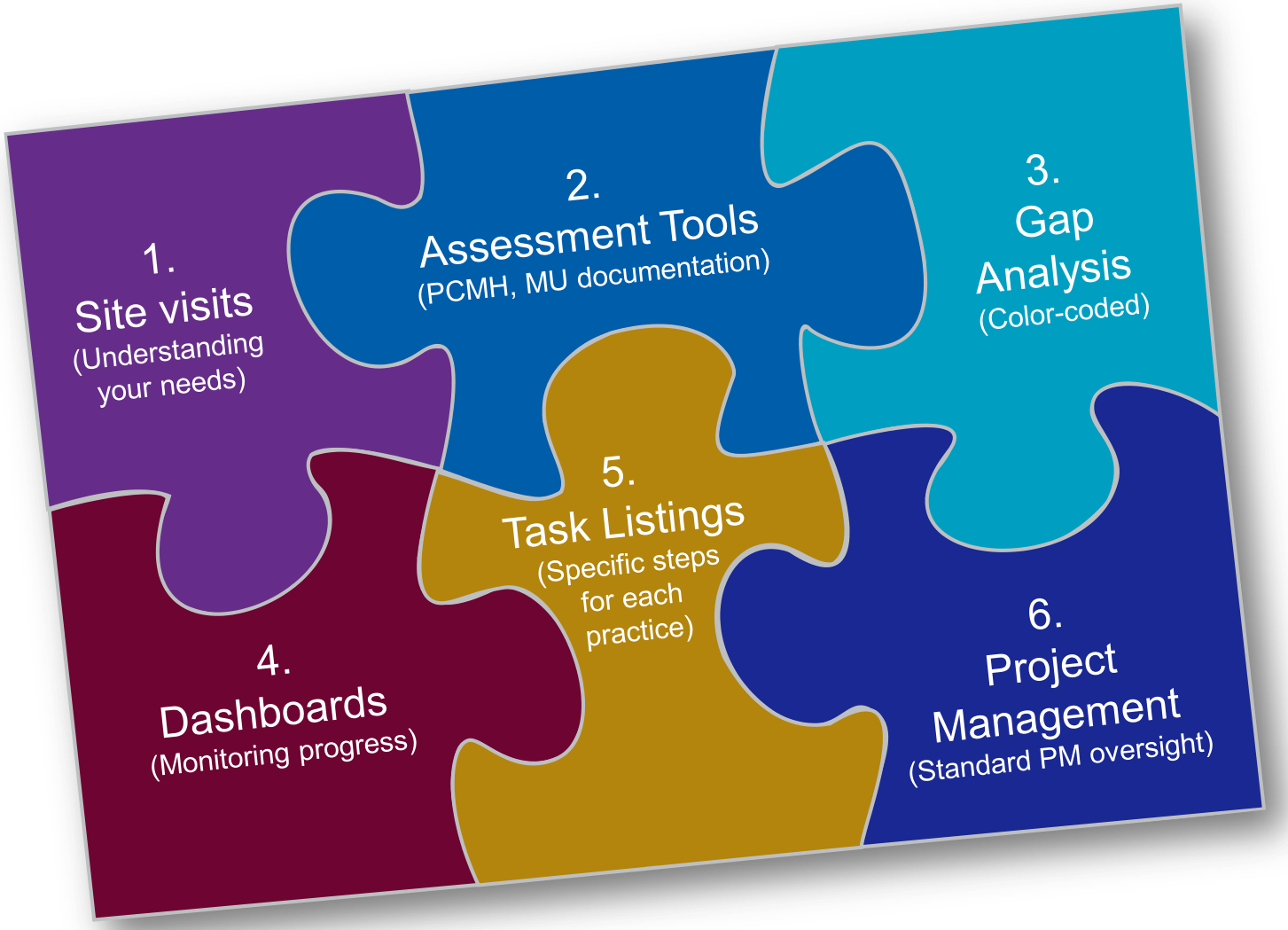
Interoperability: Other Options

What if you do not have the advantage of a strong regional HIE availability?

- Consider alignment/participation with an existing provider that has an HIE (Dignity, Sutter, UC system, Kaiser…)
- Consider exploring a State exchange (The CA Dept of Public Health maintains a state based exchange)
- Explore establishing your own HIE: CHeQ offers funding for establishment of rural HIE in CA
- Contact Regional Extension Center additional advice and assistance
- Consider opening a Direct Messaging Account as an interim solution utilizing Direct Messaging

MAKING IT HAPPEN

Our Approach for Assessing Readiness



Assessment Process: Individual Scoring

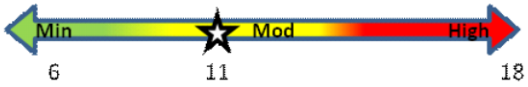
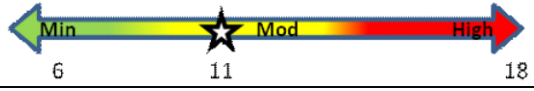
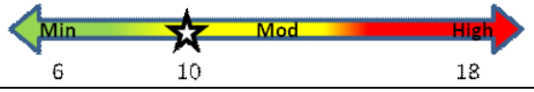
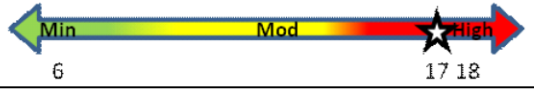
Based on Remediation Work Effort

- Green: Minimal effort anticipated
- Yellow: Moderate work effort expected
- Red: Intense work effort indicated

Two levels of scoring

- Detailed MU and PCMH (Measures and Standards)
  - 6 PCMH Standards
  - Stage 1 and Stage 2 (Core, Menu, and CQMs)
- Criteria Evaluation of MU and PCMH
  - Governance
  - Technology
  - Workflow
  - Reporting
  - Compliance
  - Audit

Rapid Assessment: Six Criteria

Categories Description and Work Effort		Support	Criteria Governance	Technology	Workflow	Reporting	Compliance	Audit
	PCMH - 2014							
1	Standard 1 - Access		1	2	2	1	2	3
			Practice does have same day access; needs to improve phone triage system for timeliness and remove VM systems					
2	Standard 2 - Team Based Care		2	1	2	1	2	3
			Practice does consider continuity with scheduling; would like to improve teams; measures compliance though does not have clear path of improvement					
3	Standard 3 - Population Health Management		1	1	2	2	2	2
			Has reportable discreet fields; need to improve their use of templates; need to expand their pop health and QI program and use of CDS					
4	Standard 4 - Care Management and Support		2	1	2	2	2	3
			Needs to identify high risk groups and patients in need of CM; has to firm up CM program to improve outcomes; need to document goals and barriers more effectively, and utilize shared care plans					
5	Standard 5 - Care Coordination & Care Transitions		2	3	3	3	3	3
			Area of largest improvements around test tracking work flow and supporting technologies; needs process for care transitions					
6	Standard 6 - Performance Measurement and QI		2	2	2	2	2	2
			Recent establishment of QI program needs to consider care coordination role and measuring effectiveness of role; needs to institute PDSA cycles and re-measurement cycles that effect improvements					

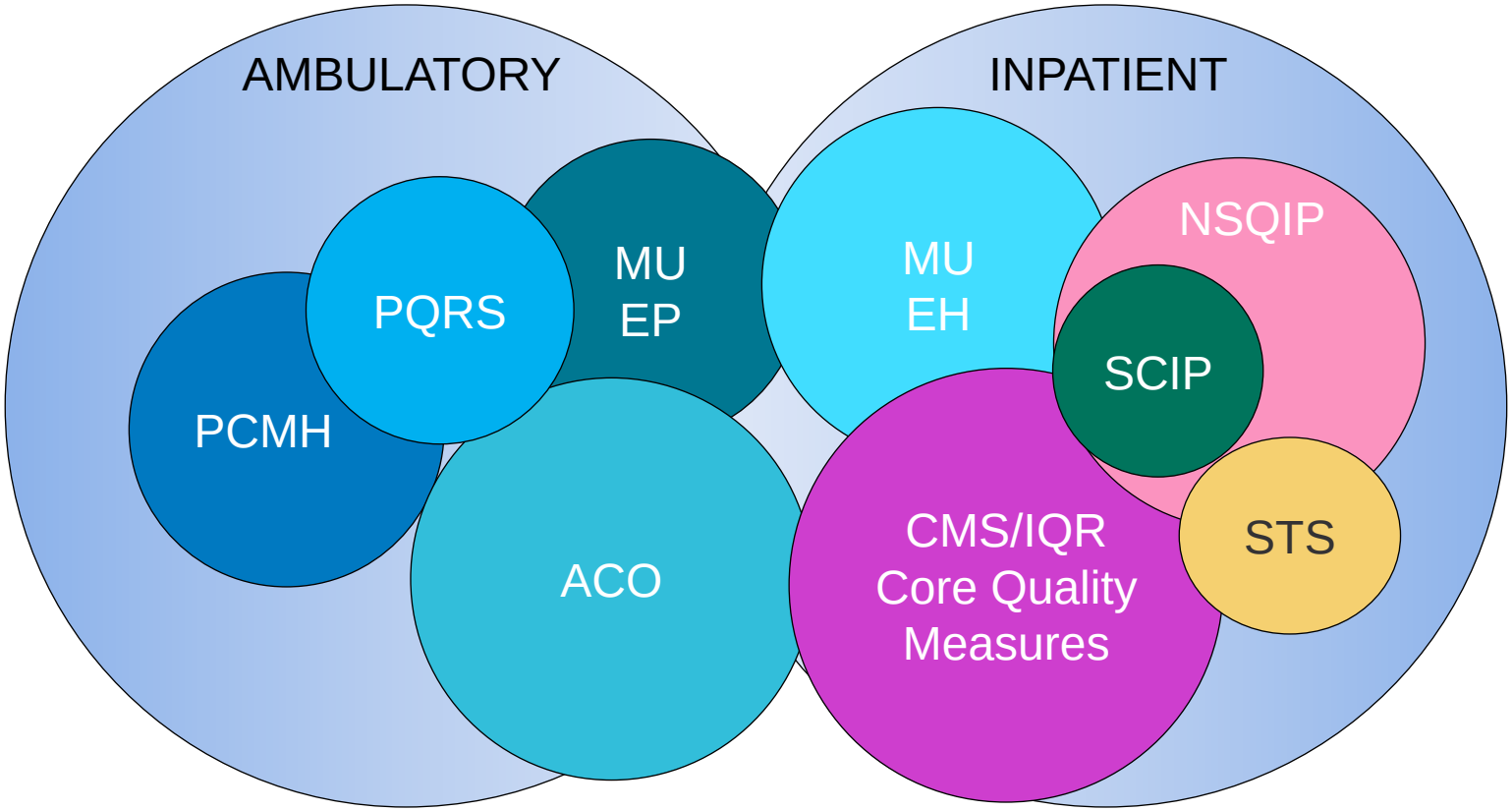
Rapid Assessment: Summary

Organization		Standard 1	Standard 2	Standard 3	Standard 4	Standard 5	Standard 6	Stage 1			Stage 2		
	Name	Access	Teams	Pop Hlth	Care Mgt	Care Coord	Perf/QI	Core	Menu	CQM	Core	Menu	CQM
1	Primary Care, Special POP	12	12	16	13	17	18	10	10	13	16	14	17
2	FQHC-1	8	12	13	14	17	18	7	9	12	14	11	12
3	Article 28, 16, 31	8	12	12	13	13	15	7	7	7	10	9	10
4	Article 28, 16, 31	12	13	11	11	13	16	7	7	7	12	9	7
5	FQHC-2	12	17	18	14	17	18	15	15	18	17	17	18
6	FQHC-3	11	8	6	12	17	6	9	10	8	14	8	8
7	Article 28, 16, 31	11	8	13	17	14	16	10	8	16	14	10	16
8	FQHC-4	6	8	6	10	10	11	8	9	8	10	9	8
9	FQHC-5	11	11	10	12	17	12	9	9	7	12	9	7
10	Hospital-based Clinic	14	15	16	15	15	17	14	13	16	16	13	16
11	Hospital-based Clinic	12	12	15	17	13	17	7	7	7	14	7	7

Legend	
6-9	Light Support
10-14	Moderate Support
15-18	Intense Support

Finding Synergies: Quality Measure Overlap

Identify overlaps to streamline processes



Findings: MU/PCMH/UDS Cross Walk

CMS Adult and Pediatric Recommended Measures

5 Pediatric Core CQMs Align with UDS Clinical Performance Measures

1. Childhood Immunization Status
2. Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents
3. Use of Appropriate Medications for Asthma
4. Children Who Have Dental Decay or Cavities
5. Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan

4 Adult Core CQMs Align with UDS Clinical Performance Measures

1. Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up
2. Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
3. Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan
4. Controlling High Blood Pressure

No.	2014 HRSA UDS Clinical Performance Measures	X - UDS CPMs aligned with eCQMs and PCMH	2014 CQM Name	Adult/Pediatric Recommended Core Set	PCMH 2014 Standards	CMS Domain
1	Percentage of children with their 3rd birthday during the measurement year or January 1st of the following year who are fully immunized before their third birthday.	X	CMS 117v2; NQF 0038 Childhood Immunization Status	Pediatric	PCMH Standard 6A1	Population/ Public Health
2	Percentage of women 21-64 years of age who received one or more tests to screen for cervical cancer	X	CMS 124v2; NQF 0032 Cervical Cancer Screening		PCMH Standard 6A2	Clinical Process/ Effectiveness
3	Percentage of patients aged 2 until 17 who had evidence of BMI percentile documentation AND who had documentation of counseling for nutrition AND who had documentation of counseling for physical activity during the measurement year	X	CMS 155v2; NQF 0024 Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Pediatric	PCMH Standards 3E4; 6A3	Population/ Public Health
4	Percentage of patients aged 18 and older who had documentation of a calculated BMI during the most recent visit or within the six months prior to that visit and if the most recent BMI is outside parameters, a follow-up plan is documented.	X	CMS 69v2; NQF 0421 Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up - Adult	Adult	PCMH Standard 3E4; 6A3	Population/ Public Health
5	Percentage of patients age 18 years and older who were screened for tobacco use at least once during the measurement year or prior year AND who received cessation counseling intervention and/or pharmacotherapy if identified as a tobacco	X	CMS 138v2, NQF 0028 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Adult	PCMH Standard 3E4; 6A2	Population/ Public Health
6	Percentage of patients aged 5 through 40 with a diagnosis of mild, moderate, or severe persistent asthma who received or were prescribed accepted pharmacologic therapy	X	CMS 126v2; NQF 0036 Use of Appropriate Medications for Asthma	Pediatric	PCMH Standard 3E; 6A	Clinical Process/ Effectiveness
7	Percentage of patients aged 18 years and older who were discharged alive for acute myocardial infarction (AMI) or coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) from January 1 to November 1 of the prior year OR who had a diagnosis of ischemic vascular disease during the measurement year who had documentation of use of aspirin or another antithrombotic	X	CMS 164v2; NQF 0068 Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic		PCMH Standard 6A2	Clinical Process/ Effectiveness
8	Percentage of patients aged 50 to 75 who had appropriate screening for colorectal cancer	X	CMS 130v2; NQF 0034 Colorectal Cancer Screening		PCMH Standard 6A1	Clinical Process/ Effectiveness
9	Percentage of patients aged 12 and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented	X	CMS 2v3, NQF 0418 Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	Both	PCMH Standard 6A1	Population/ Public Health
10	Percentage of newly diagnosed HIV patients who had a medical visit for HIV care within 90 days of first-ever HIV diagnosis	X	CMS 62v2; NQF 0403 HIV/AIDS: Medical Visit		PCMH Standards 3D4; 6B	Clinical Process/ Effectiveness
11	Percentage of adult patients 18 to 75 years of age with a diagnosis of Type I or Type II diabetes, whose hemoglobin A1c (HbA1c) was less than or equal to 9% at the time of the last reading in the measurement year	X	CMS 122v2; NQF 0059 Diabetes: Hemoglobin A1c Poor Control		PCMH Standards 3D2; 6B	Clinical Process/ Effectiveness
12	Percentage of patients 18 to 85 years of age with diagnosed hypertension (HTN) whose blood pressure (BP) was less than 140/90 at the time of the last reading	X	CMS 165v1 NQF 0018 Controlling High Blood Pressure	Adult	PCMH Standard 3B	Clinical Process/ Effectiveness
13	Additional Measures: In addition to the above UDS clinical measures, health centers must include one Oral Health performance measure of their choice.	X	CMS 75v3; NQF (TBD) Children Who Have Dental Decay or Cavities	Pediatric	PCMH Standard 6A2	Clinical Process/ Effectiveness

Both Adult/ Ped

Population Health Management

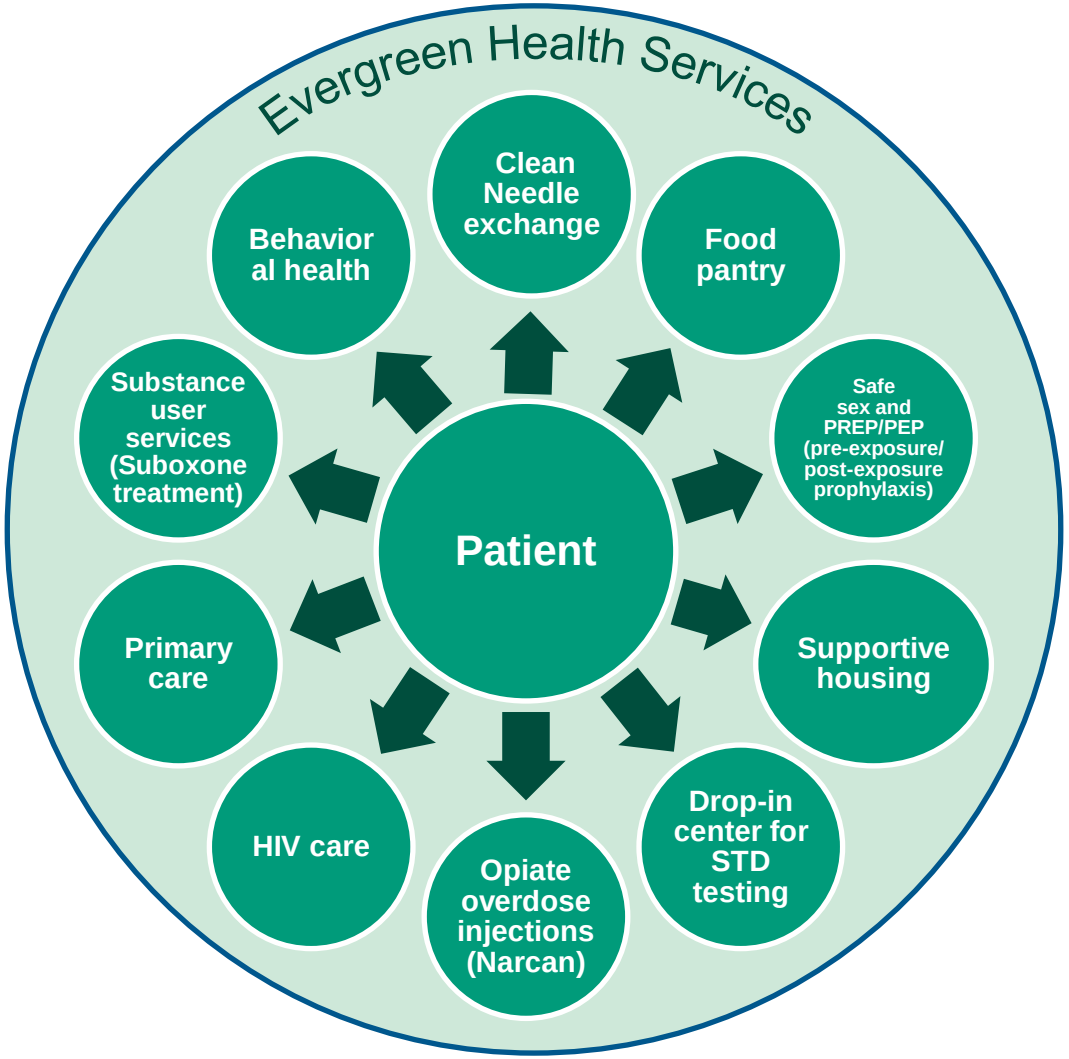
How are you identifying your high-risk populations?

- Identification of high-risk patient populations
  - Diagnosis, co-morbidities, utilization patterns, labs, demographics and social determinants…
- Risk stratification
  - Low, medium, and high
- Interventions
  - Highest risk consumes most resources
- Coordination of care longitudinally

CASE STUDIES

Meeting the Patient Where They Are!

Harm reduction model with non-judgment: wrap-around services to begin trust relationship



Holistic Approach to Addressing Changing Population Demographics

WNY has the highest rate of refugee immigration in NYS

- Many refugee patients: HIV+ patients from Burma
  - Burma: behind in science for HIV care
- First priority: improving viral load reduction
- Wrap-around services (providing safe entry for patients needing care)
- Many services added to address Burmese population
- Great entry to begin trust relationship for primary care
- Sustainability and transitional support

Case Study: Diabetic Health Outcomes

Challenge: Improve diabetic healthcare for high-risk, low-income populations in a manner that meets the patient where they are

Rural: Amish community

- No phones
- Cultural barriers
- Cooking restrictions

Urban: FQHC population

- High Medicaid
- Fast food diet
- High no-show rate

Case Study: Paper to EHR to PCMH Excellence

Start at the beginning

- CTG developed 45 project tools for distribution to each site
- Policy and procedures, call logs, and other PCMH tools were created
- Baseline statistics collected for PCMH using a standardized tools (APC)
- Each practice conducted Diabetic Outcome quality studies.
- Consistent sampling was conducted at each site using NCQA sampling selection methodology

Introduction of Technology

By applying key technology, practices were able to leverage advanced workflows to drive improved outcomes in a cost-effective manner

Introduction to EHR

- Using PCMH improve workflows
- Remove paper flow
- Develop electronic messaging
- Reporting and quality measurement

Access to HIE (HEALTHeLINK)

- Interface for results delivery
- ADT for transitions in care
- Home care results download
- Medication reconciliation through SureScript Medication History

Case Study: Applying Tools for Outcomes

Building on progress and prior success

- The consultants demonstrated how chronic disease can be managed at a population level and patient point of care level by including EHR template changes
- Practices began experiencing eye-opening opportunities to begin their journey towards quality, pay for performance, and meaningful use
- Offered access to local HIE and as a result, additional community providers and services
- Developed enhanced workflows with technology to drive better outcomes

Diabetic Patient Outcomes

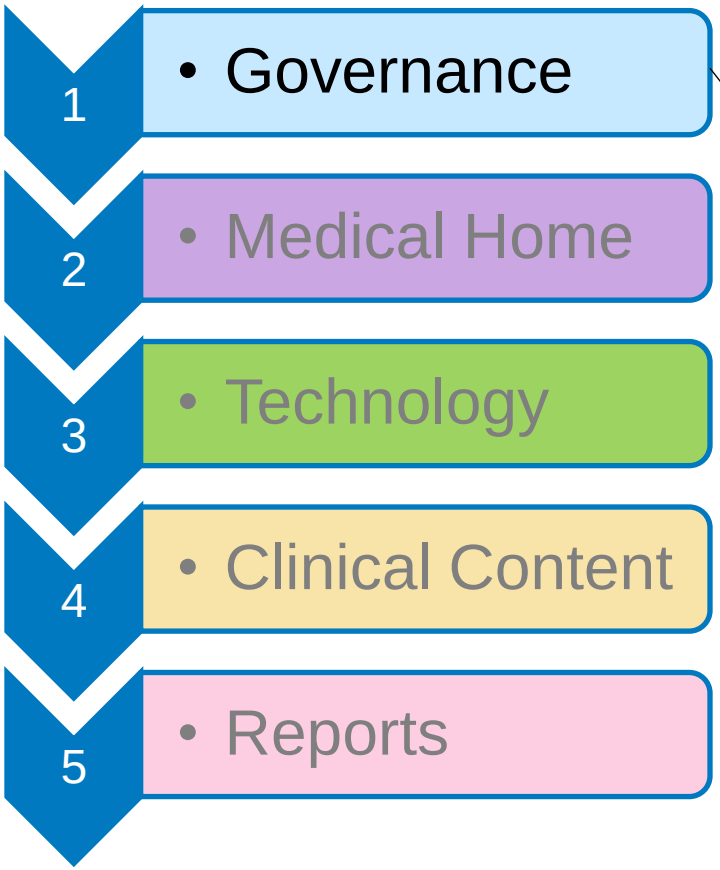
Objective:

- Demonstrate chronic disease can be managed at the population level as well as at the patient level

Population Improvement	Result
Overall improvement in HgbA1C	77.4%
At or below HgbA1C of 7.0 or showed improvement.	77.4%
At or below LDL of 100 or showed improvement	80.3%
Systolic BP was at or below 130	78.6%
Diastolic BP was at or below 80 or showed improvement.	83.7%

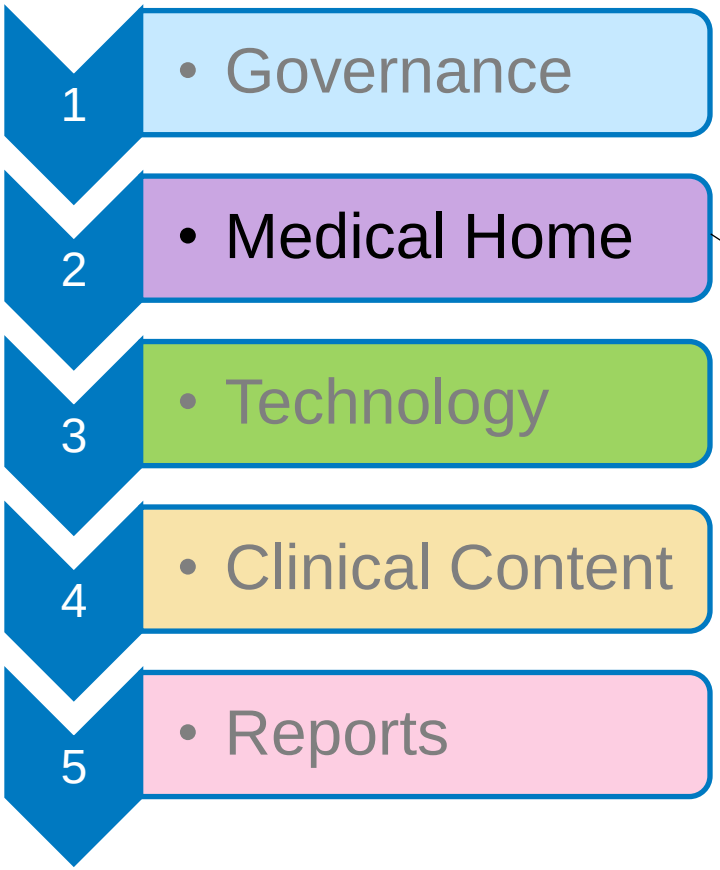
ORGANIZATIONAL SELF-ASSESSMENT TOOL

Self-Assessment: Governance



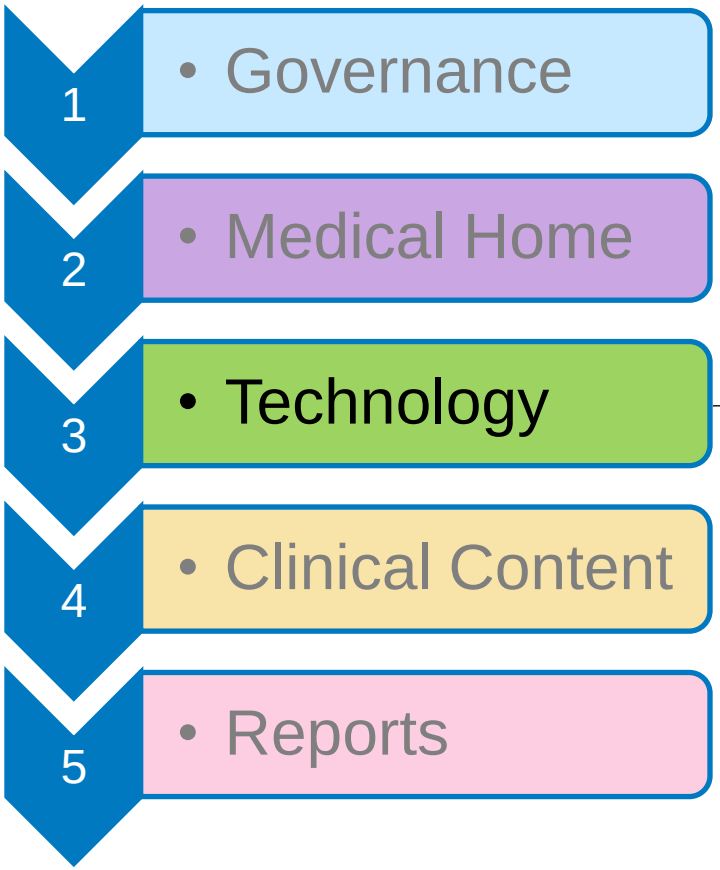
- Is there a overall multidisciplinary governance structure in place to work with practices to:
  - Vision-driven decision process?
  - Identify and define goals?
  - Manage expectations against set goals?
  - Provide intervention and escalation as needed
- Establish and drive PDSA cycles for improvement

Self-Assessment: Medical Home



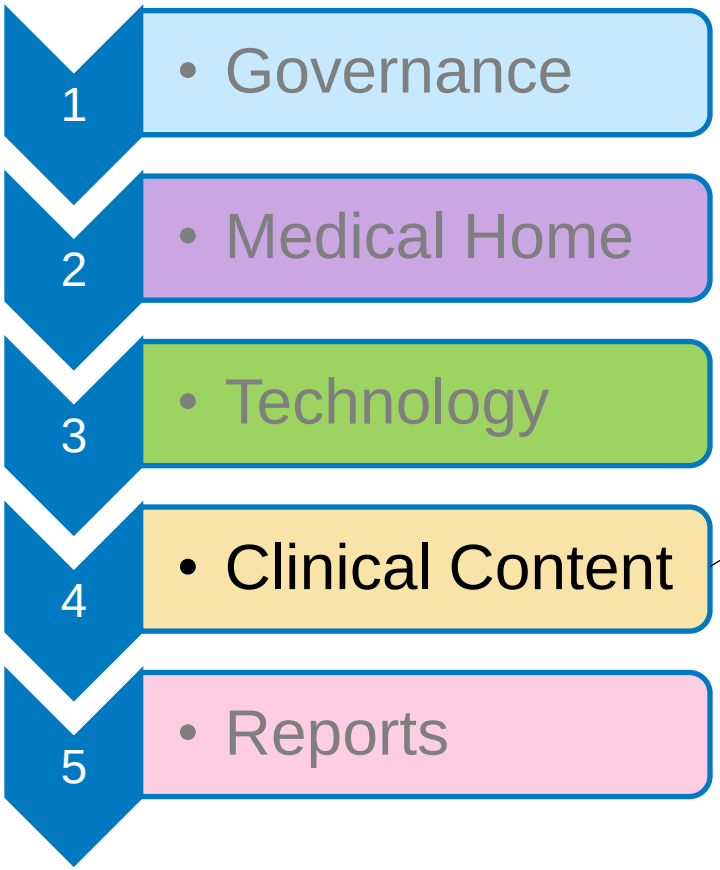
- Do you have a comprehensive approach for encompassing and providing total patient care?
- Do you have a structure in place that supports same day access?
- Do you care team members provide care at the height of their license?
- Can you identify and manage high-risk populations
- Di have Performance Measurements and Quality Improvements?

Self-Assessment: Technology



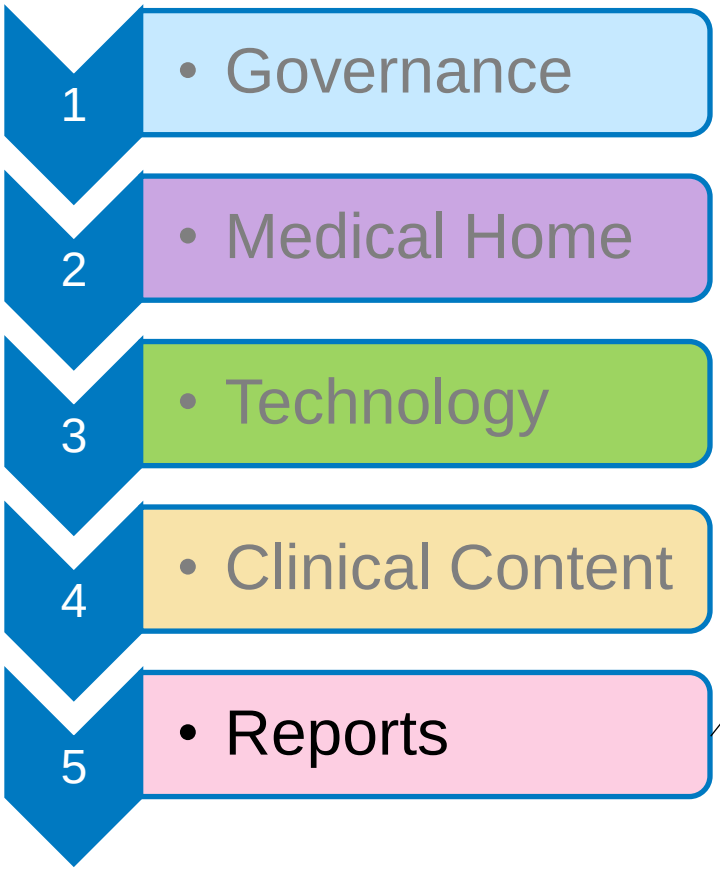
- Is your technology sufficient to identify your target populations?
- Can your technology support transitions of care/summaries?
- Does your technology provide opportunities for pt engagement?
- Do you have an HIE for interoperability?
- Do you have CDS that guides clinicians to best practice?

Self-Assessment: Clinical Content



- Are there standardized guidelines for capture of patient care data?
- Are there target conditions that are actively managed and measured across all practices?
- Is patient information captured in a consistent manner?
- Do you have a data governance approach to collecting and managing patient data?

Self-Assessment: Reports



- Do you have adequate baseline reporting to support identified metrics?
- Are reports routinely internally validated?
- Can reports be created by end-users (self-serve reporting)?
- Do you have a decision process and prioritization method for identifying reporting needs?

Survival

SURVIVAL

Survival

Survival

Survival

Evidence based content with decision support

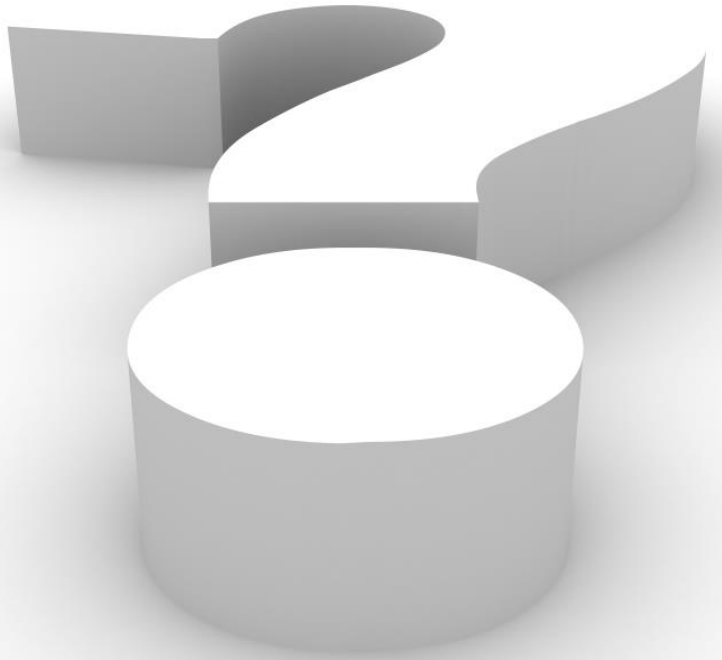
Providing the right care,
to the right patient,
at the right time,
in the right way
and being able to prove it.

EHR functionality

Workflow integration by role

Actionable Outcomes

Questions and Answers



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