Innovative Quality Improvement for Vulnerable Populations

Tuesday, March 1, 2016

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Andrew Kiener, Associate Vice President—Research and Quality Assurance, Evergreen Health Services

DISCLAIMER: The views and opinions expressed in this presentation are those of the author and do not necessarily represent official policy or position of HIMSS.

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Conflict of Interest

Jeanette Ball, RN, BSN, PCMH CCE
Has no real or apparent conflicts of interest to report.

Andrew Kiener
Has no real or apparent conflicts of interest to report.
Agenda

• Building the Foundation—PCMH 2014 and Meaningful Use Stage 2
• Population Health Management
• Case Studies
• Organizational Self-Assessment Tool
Learning Objectives

• Identify the foundational elements from PCMH and MU that enable successful population health management

• Recognize your high-risk patients by stratifying your population using social determinants of health

• Illustrate how a harm reduction model is able to support improved outcomes for marginal populations

• Perform an organizational self assessment of your readiness to effectively manage vulnerable populations and demonstrate improved outcomes
An Introduction of How Benefits Were Realized for the Value of Health IT

• Satisfaction
  – Establishment of a population management program that utilizes an organized structured methodology leads to improved patient and staff satisfaction. PCMH elements require satisfaction is measured both from the patient and staff. At Evergreen, they take patient satisfactions seriously and have patient advocates sit on their board and meet with a patient focus group quarterly where feedback is received and actions taken.

• Treatment/Clinical
  – Evergreen has demonstrated outstanding clinical outcomes using their Harm Reduction Model. They outperform state metrics in several key HIV measures including: Medication Adherence at 88%, Linkage, and retention of patients.

• Electronic Secure Data
  – Evergreen has broken the barrier with linking community action plans and treatment plans through shared care plans. Their Care Coordinators share the community data through an interface to the EMR, allowing for continuity of goal setting and barriers to treatment.

• Patient Engagement & Population Management
  – Evergreen and PCMH are focused on population health management and patient engagement being the key pieces of excellence. This is the cornerstone of this discussion.

• Savings
  – With HIV care, keeping the patient linked and medication adherence decreasing viral load is key to keeping the patient well and not accelerating the virus. This results in cost savings overall due to less ED care, less hospitalization and worsening of a chronic condition.
Introductions

Jeanette Ball, RN, BSN, PCMH CCE
Delivery Manager, CTG

28 years of healthcare experience
• 10 years in acute care and ED
• 10 years ambulatory Primary Care and Specialty administration

Expertise
• HIE development
• EHR implementation
• Practice workflow efficiencies and Medical Home clinical transformation
• NCQA Certified Patient-Centered Medical Home Content Expert

Andrew Kiener
Associate Vice President—Research and Quality Assurance, Evergreen Health Services

More than 15 years of healthcare experience with vulnerable populations and HIV/AIDS
• Co-chair for the Statewide HIV Advisory Board
• Former executive director of the AIDS Network of Western New York
• Former Voting member of New York State Prevention Planning Group for individuals at risk for HIV
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

Improved Outcomes for Providers

Improved Patient Safety and Focused Quality

DSRIP/Other Grant Opportunities

Provider Organizations

Integrated Community Solutions

Foundation: PCMH 2014 and Meaningful Use Stage 2
What is PCMH?

• Evidence continues to confirm that Patient-Centered Medical Homes deliver
  – Improved patient experience
  – Better health outcomes
  – Lead to lower cost

• Embracing the NCQA PCMH standards and guidelines, practices discover clear ways to ensure their patients receive the right care, at the right time, at the most affordable price.
Sometimes you Just Need a Roadmap

- 40,000+ clinicians at more than 9,000 primary care practice sites have earned NCQA PCMH Recognition.

- 37 states have referenced the NCQA PCMH program as a viable model to use in transforming primary care within their statewide health reform initiatives.
NCQA PCMH 2014 Standards

1) Patient-Centered Access (10)
   A) *Patient-Centered Appointment Access
   B) 24/7 Access to Clinical Advice
   C) Electronic Access

2) Team-Based Care (12)
   A) Continuity
   B) Medical Home Responsibilities
   C) Culturally and Linguistically Appropriate Services
   D) *The Practice Team

3) Population Health Management (20)
   A) Patient Information
   B) Clinical Data
   C) Comprehensive Health Assessment
   D) *Use Data for Population Management
   E) Implement Evidence-Based Decision Support

4) Care Management and Support (20)
   A) Identify Patients for Care Management
   B) *Care Planning and Self-Care Support
   C) Medication Management
   D) Use Electronic Prescribing
   E) Support Self-Care & Shared Decision Making

5) Care Coordination and Care Transitions (18)
   A) Test Tracking and Follow-Up
   B) *Referral Tracking and Follow-Up
   C) Coordinate Care Transitions

6) Performance Measurement and Quality Improvement (20)
   A) Measure Clinical Quality Performance
   Measure Resource Use and Care Coordination
   A) Measure Patient/Family Experience
   B) *Implement Continuous Quality Improvement
   C) Demonstrate Continuous Quality Improvement
   D) Report Performance
   E) Use Certified EHR Technology

* Must-pass
NCQA PCMH Recognition by State

37 States* Have Public and Private Patient-Centered Medical Home (PCMH) Initiatives That Use NCQA Recognition

Public (7)
Private (13)
Both – Including Multi-Payer (17)

*Includes the District of Columbia

March 2014
A Marriage of Two Initiatives

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

Clinical Improvements

Technology Enhancements

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

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Clinical Improvements

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

Technology Enhancements

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

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:

<table>
<thead>
<tr>
<th>PCMH</th>
<th>MU</th>
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<tbody>
<tr>
<td>• Patient-centered Access</td>
<td>• Advanced Clinical Processes</td>
</tr>
<tr>
<td>• Team-based Care</td>
<td>• Discrete and Structured Data</td>
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<tr>
<td>• Population Health Management</td>
<td>• Coordination of Care across Continuums</td>
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<tr>
<td>• Care Management and Support</td>
<td>• Patient Portal and Engagement</td>
</tr>
<tr>
<td>• Care Coordination and Care Transitions</td>
<td>• Exchange of Information</td>
</tr>
<tr>
<td>• Performance Measurement and Quality Improvement</td>
<td>• Electronic Performance Submissions</td>
</tr>
<tr>
<td></td>
<td>• Cross-continuum Care Processes</td>
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</table>
Finding Synergies: Quality Measure Overlap

Identify overlaps to streamline processes
Findings: MU/PCMH/UDS Cross ‘Walk

**CMS Adult and Pediatric Recommended Measures**

**Five 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

**Four 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

<table>
<thead>
<tr>
<th>No.</th>
<th>2014 HRSA UDS Clinical Performance Measures</th>
<th>X - UDS CPMs aligned with eCQMs and PCMH</th>
<th>2014 CQM Name</th>
<th>Adult/Pediatric Recommended Core Set</th>
<th>PCMH 2014 Standards</th>
<th>CMS Domain</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>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.</td>
<td>X</td>
<td>CMS 117v2; NQF 0038 Childhood Immunization Status</td>
<td>Pediatric</td>
<td>PCMH Standard 6A1</td>
<td>Population/ Public Health</td>
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<tr>
<td>2</td>
<td>Percentage of women 21-64 years of age who received one or more tests to screen for cervical cancer</td>
<td>X</td>
<td>CMS 124v2; NQF 0032 Cervical Cancer Screening</td>
<td>PCMH Standard 6A2</td>
<td>Clinical Process/ Effectiveness</td>
<td></td>
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<tr>
<td>3</td>
<td>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</td>
<td>X</td>
<td>CMS 155v2; NQF 0024 Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents</td>
<td>Pediatric</td>
<td>PCMH Standard 3E4; 6A3</td>
<td>Population/ Public Health</td>
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<tr>
<td>4</td>
<td>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.</td>
<td>X</td>
<td>CMS 69v2; NQF 0421 Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up - Adult</td>
<td>Adult</td>
<td>PCMH Standard 3E4; 6A3</td>
<td>Population/ Public Health</td>
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<tr>
<td>5</td>
<td>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 user.</td>
<td>X</td>
<td>CMS 138v2, NQF 0028 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention - Adult</td>
<td>Adult</td>
<td>PCMH Standard 3E4; 6A2</td>
<td>Population/ Public Health</td>
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<tr>
<td>6</td>
<td>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</td>
<td>X</td>
<td>CMS 126v2; NQF 0036 Use of Appropriate Medications for Asthma</td>
<td>Pediatric</td>
<td>PCMH Standard 3E; 6A</td>
<td>Clinical Process/ Effectiveness</td>
</tr>
<tr>
<td>7</td>
<td>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</td>
<td>X</td>
<td>CMS 164v2; NQF 0068 Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic</td>
<td>PCMH Standard 6A2</td>
<td>Clinical Process/ Effectiveness</td>
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<tr>
<td>8</td>
<td>Percentage of patients aged 50 to 75 who had appropriate screening for colorectal cancer</td>
<td>X</td>
<td>CMS 130v2; NQF 0034 Colorectal Cancer Screening</td>
<td>PCMH Standard 6A1</td>
<td>Clinical Process/ Effectiveness</td>
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<tr>
<td>9</td>
<td>Percentage of patients aged 12 and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented</td>
<td>X</td>
<td>CMS 2v3, NQF 0418 Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan</td>
<td>Both</td>
<td>PCMH Standard 6A1</td>
<td>Population/ Public Health</td>
</tr>
<tr>
<td>10</td>
<td>Percentage of newly diagnosed HIV patients who had a medical visit for HIV care within 90 days of first-ever HIV diagnosis</td>
<td>X</td>
<td>CMS 62v2; NQF 0043 HIV/AIDS: Medical Visit</td>
<td>PCMH Standards 3D4; 6B</td>
<td>Clinical Process/ Effectiveness</td>
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<td>11</td>
<td>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</td>
<td>X</td>
<td>CMS 122v2; NQF 0059 Diabetes: Hemoglobin A1c Poor Control</td>
<td>PCMH Standards 3D2; 6B</td>
<td>Clinical Process/ Effectiveness</td>
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<tr>
<td>12</td>
<td>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</td>
<td>X</td>
<td>CMS 165v1, NQF 0018 Controlling High Blood Pressure</td>
<td>Adult</td>
<td>PCMH Standard 3E</td>
<td>Clinical Process/ Effectiveness</td>
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<tr>
<td>13</td>
<td>Additional Measures: In addition to the above UDS clinical measures, health centers must include one Oral Health performance measure of their choice.</td>
<td>X</td>
<td>CMS 75v3; NQF (TBD) Children Who Have Dental Decay or Cavities</td>
<td>Pediatric</td>
<td>PCMH Standard 6A2</td>
<td>Clinical Process/ Effectiveness</td>
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</table>
Health Information Exchange (HIE)—“The Noun”
The Key to Functionality: Interoperability

<table>
<thead>
<tr>
<th>HEALTHeLINK, the Western New York HIE, was created with the following goals:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Improve Clinical Interoperability throughout the community</td>
</tr>
<tr>
<td>• Optimize the use of technology for chronic disease management through the HIE</td>
</tr>
<tr>
<td>• Decrease redundant unnecessary testing</td>
</tr>
<tr>
<td>• Point-of-Care access to up-to-date patient information</td>
</tr>
<tr>
<td>• Increase the number of PCMH-modeled practices to improve primary care</td>
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</table>
HEALTHeLINK Progress

<table>
<thead>
<tr>
<th>Success</th>
<th>Challenges</th>
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</thead>
<tbody>
<tr>
<td>700,000 patient consents</td>
<td>Not accessible in EMR directly</td>
</tr>
<tr>
<td>21 direct vendor interfaces</td>
<td>HL7 data inconsistent</td>
</tr>
<tr>
<td>All hospitals in the Western New York region</td>
<td>Normalizing CCD data</td>
</tr>
<tr>
<td>Quest Diagnostics</td>
<td>Data analytics</td>
</tr>
<tr>
<td>Home care monitoring</td>
<td>State connections to Medicaid</td>
</tr>
<tr>
<td>Medical Home alerts</td>
<td></td>
</tr>
</tbody>
</table>
Finding the Answers

VHR Patient Queries 2014-2015

- VA
- XGateway
- Retrieve
- Rad Images
- Viewed
- Med
- Queries
- VHR
- Transcriptions
POPULATION HEALTH MANAGEMENT
Population Health Management

How are you identifying your high-risk populations?

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

How are you identifying your high-risk populations?
Population Health
What factors affect the health of a community?

- Education
- Employment
- Income
- Family/social support
- Access to care
- Quality of care
- Smoking
- Exercise
- STD

- Health Behaviors 30%
- Clinical Care 10%
- Physical Environment 20%
- Social and Economic Factors 40%

Erie County Ranks 54th of 62 Counties in NYS for 2015 For Health Outcomes
Source: www.countyhealthrankings.org
How does PCMH assist a practice in strengthening its QA program?

1. PCMH helps align a practice’s priority QA activity
2. PCMH provides guidelines for stratification of populations
3. Renewal of PCMH requires proof of ongoing activities through every year of recognition
4. All of the above
CASE STUDIES
Evergreen Health Services
Reduce Harm!
Specializing in Marginal Populations
• Primary Care
• HIV
• LGBTQ
• Substance Using
• STD Clinic
• Art Therapy
• Music Therapy
• Food Pantry
• Housing
• Case Management
• Needle Exchange
• Urban Garden
• Case Management
• Supportive Housing
Before and After
Meeting the Patient Where They Are!

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

- Clean needle exchange
- Food pantry
- Safe sex and PREP/PEP (pre-exposure/post-exposure prophylaxis)
- Supportive housing
- Drop-in center for STD testing
- Opiate overdose injections (Narcan)
- HIV care
- Primary care
- Substance user services (Suboxone treatment)
- Behavioral health

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You Cannot Help Your Population Until You Understand Them!

### Association Demographics of Individuals Receiving Services

Total Number of Individuals Receiving at Least One Service: 12,216  
Number of Individuals Living with HIV/AIDS: 1,399

<table>
<thead>
<tr>
<th>Gender</th>
<th>Race</th>
<th>Unique Populations Served</th>
<th>Age</th>
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</thead>
<tbody>
<tr>
<td>Male</td>
<td>Black</td>
<td>Gay/Bisexual</td>
<td>0-12</td>
<td>34</td>
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<tr>
<td>Female</td>
<td>Hispanic</td>
<td>Injection Drug User</td>
<td>13-19</td>
<td>509</td>
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<td>Transgender</td>
<td>White</td>
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<td>20-29</td>
<td>4611</td>
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<td></td>
<td>Native</td>
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<td>30-39</td>
<td>2886</td>
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<td></td>
<td>Other</td>
<td></td>
<td>40-49</td>
<td>2047</td>
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<td></td>
<td>50-59</td>
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<td>60-69</td>
<td>98</td>
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<td></td>
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<td>70+</td>
<td>54</td>
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## Evergreen Association of Western New York, Inc.

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<tr>
<th>Evergreen Health Services</th>
<th>Testing Program</th>
<th>Pride Center</th>
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<tbody>
<tr>
<td>Harm Reduction Counseling</td>
<td>HIV/AIDS Tested</td>
<td>Trainings</td>
</tr>
<tr>
<td>Harm Reduction Group Participants</td>
<td>Number Testing HIV Positive</td>
<td>Referrals for Health/ Mental Health</td>
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<tr>
<td>Sexual Health Screening/Treat</td>
<td>STI/STD Tested</td>
<td>Program Participants</td>
</tr>
<tr>
<td>Regional Syringe Exchange Programs</td>
<td>Numbers Testing Positive</td>
<td>Information Requests</td>
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<tr>
<td>Individuals Exchanging</td>
<td>Hep C Tested</td>
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<tr>
<td>Syringes Exchanged</td>
<td>Number Testing Positive</td>
<td>Community Access Services</td>
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<tr>
<td>Wellness Center</td>
<td></td>
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<tr>
<td>Members</td>
<td>473</td>
<td>Harm Reduction Counseling</td>
</tr>
<tr>
<td>Lunches served (50/day)</td>
<td>13000</td>
<td>Harm Reduction Groups</td>
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<tr>
<td>Groups Provided</td>
<td>200</td>
<td></td>
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<tr>
<td>Active Participants</td>
<td>178</td>
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### Evergreen Association of Western New York, Inc. (cont’d)

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<td>Referrals for Health/ Mental Health</td>
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<td>445</td>
<td>18</td>
<td>105</td>
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<td>Sexual Health Screening/Treat</td>
<td>STI/STD Tested</td>
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<td>Syringes Exchanged</td>
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<tr>
<td>178</td>
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Measuring Health Outcomes using Social Determinants of Health

How does Neighborhood Culture effect outcomes

- Safety
- Availability of Whole Foods
- Cultural Norms
- Economics
- Public Transportation access
- Violence
- Drugs
Holistic Approach for Addressing Marginalized Populations

- 85% Medicaid
- Many Refuge Patients: HIV-Positive Patients from Burma
  - Burma: Behind in science for HIV care first priority improving Viral load reduction
- WNY has the highest rate of refugee populations in NYS
- Wrap-Around Services (providing safe entry for patients needing care)
- Lunch program:
  - Great entry to begin trust relationship for primary care
- Purchase of mobile van to provide HIV, HEP C, STI treatment and linkage support services including primary care
- Taking care the LGBTQ communities
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
Evergreen Health Services HIV Care vs. US National and NY State HIV Care

- EMG Continuous Care percentage is 97% compared to US 37% and NYS 56%
- EMG Prescribed ART percentage is 96% compared to US 50%
- EMG Virally Suppressed percentage (<200/ml) is 87% compared to US 38% and NYS 79%
- Of those virally suppressed – 87% have lab results reflecting <20/ml
Question 2/Slide 39

How does a harm reduction model improve care of marginal populations?

1. By meeting patients “where they are”
2. Establishing trust relationship
3. By trying to shame them into fixing their problems
4. 1 and 2
Case Study: Diabetic Health Outcomes in Different Environments

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
• 550 inpatient beds
• Primary care centers on and off campus
• More than 30 outpatient specialty care services
• Regional center for trauma, burn care, transplantation, and rehabilitation services
• Major teaching facility for the University of Buffalo
• Behavioral Health Center of Excellence

http://www.ecmc.edu/about/
An Urban Health Community: A Snapshot

- 80% of the population is African American
- The average household watches 56 hours of TV per week
- Average household consumes 13+ meals a week at a fast food restaurant
- No grocery stores, but 15 Cricket Wireless stores
- 22% of households are single-parent
- 84% of the adult population has less than an Associate’s degree
- 31% live below the federal poverty line
- Only 60% of the available workforce is employed

- Home values are 85% lower than NYS average
- 16% of homes lack basic kitchen facilities
- 9.8% of homes lack proper plumbing
- Leads Erie County in:
  - Obesity
  - Diabetes
  - Heart disease
  - Preventable hospital admissions
  - Inappropriate ER utilization

*Based on aggregate data from five zip codes surrounding ECMC

Source: Onboard Informatics and The National Directors of Health Promotion and Education
Unique Challenges of PCMH in a Residency Program

- Time
- Continuity
- Knowledge
- Communication
- Coordination
- Awareness of community resources and programs
- Resident requirements
- Cultural challenges
Successes

• Successful team concept implementation
• Transition of Care program initiated, which includes home visits for patients meeting specific criteria
• Patient Action teams created
• Availability of same-day appointments
• Pre-visit planning and team huddles
• Weekly education sessions with residents
• Utilization of staff to top of licensure
• Provider and clinical champions identified
• Embedment of a Depression Care Manager within Primary Care
• UB Residency Program changing to 5:1 Model
ECMC Community Initiatives

- Camp 9-1-1
- Family-centered wellness program being developed for local school
- Influenza immunization clinics held at local churches
- “Let’s Get Moving” Community Health Fair
- The Mammography Bus
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 were 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.

<table>
<thead>
<tr>
<th>Introduction to EHR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use PCMH to improve workflows</td>
</tr>
<tr>
<td>Remove paper flow</td>
</tr>
<tr>
<td>Develop electronic messaging</td>
</tr>
<tr>
<td>Reporting and quality measurement</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Access to HIE (HEALTHeLINK)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interface for results delivery</td>
</tr>
<tr>
<td>ADT for transitions in care</td>
</tr>
<tr>
<td>Home care results download</td>
</tr>
<tr>
<td>Medication reconciliation through SureScript Medication History</td>
</tr>
</tbody>
</table>
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 that can be managed at the population level as well as at the patient level

<table>
<thead>
<tr>
<th>Population Improvement</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall improvement in HgbA1C</td>
<td>77.4%</td>
</tr>
<tr>
<td>At or below HgbA1C of 7.0 or showed improvement</td>
<td>77.4%</td>
</tr>
<tr>
<td>At or below LDL of 100 or showed improvement</td>
<td>80.3%</td>
</tr>
<tr>
<td>Systolic BP was at or below 130</td>
<td>78.6%</td>
</tr>
<tr>
<td>Diastolic BP was at or below 80 or showed improvement.</td>
<td>83.7%</td>
</tr>
</tbody>
</table>
ORGANIZATIONAL SELF-ASSESSMENT TOOL
Assessing Readiness

1. Site visits (Understanding your needs)
2. Assessment Tools (MU documentation, PCMH)
3. Gap Analysis (Color-coded)
4. Dashboards (Monitoring progress)
5. Task Listings (Specific steps for each practice)
6. Project Management (Standard PM oversight)
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)
  - Six 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

<table>
<thead>
<tr>
<th>Categories</th>
<th>Description and Work Effort</th>
<th>Support</th>
<th>Governance</th>
<th>Technology</th>
<th>Workflow</th>
<th>Reporting</th>
<th>Compliance</th>
<th>Audit</th>
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</thead>
<tbody>
<tr>
<td>PCMH - 2014</td>
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<tr>
<td>1 Standard 1 - Access</td>
<td>Practice does have same day access; needs to improve phone triage system for timeliness and remove VM systems</td>
<td>1</td>
<td></td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Min 6</td>
<td>11</td>
<td>18</td>
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</tr>
<tr>
<td>2 Standard 2 - Team Based Care</td>
<td>Practice does consider continuity with scheduling; would like to improve teams; measures compliance though does not have clear path of improvement</td>
<td>2</td>
<td></td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>3 Standard 3 - Population Health Management</td>
<td>Has reportable discreet fields; need to improve their use of templates; need to expand their pop health and QI program and use of CDS</td>
<td>1</td>
<td>1</td>
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<td>2</td>
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<tr>
<td>4 Standard 4 - Care Management and Support</td>
<td>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</td>
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<td>1</td>
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<td>2</td>
<td>3</td>
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<tr>
<td>5 Standard 5 - Care Coordination &amp; Care Transitions</td>
<td>Area of largest improvements around test tracking work flow and supporting technologies; needs process for care transitions</td>
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<tr>
<td>6 Standard 6 - Performance Measurement and QI</td>
<td>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</td>
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## Rapid Assessment: Summary

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<tr>
<th>Organization</th>
<th>Standard 1</th>
<th>Standard 2</th>
<th>Standard 3</th>
<th>Standard 4</th>
<th>Standard 5</th>
<th>Standard 6</th>
<th>Stage 1</th>
<th>Stage 2</th>
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<tbody>
<tr>
<td>Name</td>
<td>Access</td>
<td>Teams</td>
<td>Pop Hlth</td>
<td>Care Mgt</td>
<td>Care Coord</td>
<td>Perf/QI</td>
<td>Core</td>
<td>Menu</td>
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<td>1 Primary Care, Special POP</td>
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<td>3 Article 28, 16, 31</td>
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<td>4 Article 28, 16, 31</td>
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<tr>
<td>7 Article 28, 16, 31</td>
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<td>10 Hospital-based Clinic</td>
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<td>11 Hospital-based Clinic</td>
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### Legend

<table>
<thead>
<tr>
<th>Score Range</th>
<th>Support Level</th>
</tr>
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<tbody>
<tr>
<td>6-9</td>
<td>Light Support</td>
</tr>
<tr>
<td>10-14</td>
<td>Moderate Support</td>
</tr>
<tr>
<td>15-18</td>
<td>Intense Support</td>
</tr>
</tbody>
</table>
Self-Assessment: Governance

1. Governance
   - Is there an overall multidisciplinary governance structure in place to work with practices to:
     o Have a vision-driven decision process?
     o Identify and define goals?
     o Manage the expectations against set goals?
     o Provide intervention and escalation as needed?

2. Medical Home

3. Technology

4. Clinical Content

5. Reports

• Establish and drive PDSA cycles for improvement
Self-Assessment: Medical Home

1. Governance
   - Do you have a comprehensive approach for encompassing and providing total patient care?

2. Medical Home
   - Do you have a structure in place that supports same-day access?
   - Do your care team members provide care at the height of their license?

3. Technology
   - Can you identify and manage high-risk populations
   - Do you have Performance Measurements and Quality Improvements?

4. Clinical Content

5. Reports
Self-Assessment: Technology

1. Governance
   - Is your technology sufficient to identify your target populations?

2. Medical Home
   - Can your technology support transitions of care/summaries?

3. Technology
   - Does your technology provide opportunities for patient engagement?
   - Do you have an HIE for interoperability?
   - Do you have CDS that guides clinicians to best practice?
Self-Assessment: Clinical Content

1. Governance
   - Are there standardized guidelines for capture of patient care data?

2. Medical Home
   - Are there target conditions that are actively managed and measured across all practices?

3. Technology
   - Is patient information captured in a consistent manner?

4. Clinical Content
   - Do you have a data governance approach for collecting and managing patient data?

5. Reports
Self-Assessment: Reports

1. Governance
   - Do you have adequate baseline reporting to support identified metrics?

2. Medical Home
   - Are reports routinely internally validated?

3. Technology
   - Can reports be created by end users (self-serve reporting)?

4. Clinical Content
   - Do you have a decision process and prioritization method for identifying reporting needs?

5. Reports
A Summary of How Benefits Were Realized for the Value of Health IT

- **Satisfaction**—Establishment of a population management program that utilizes an organized structured methodology leads to improved patient and staff satisfaction. PCMH elements require satisfaction is measured both from the patient and staff. They also require PDSA cycles be conducted specific to satisfaction improvement. At Evergreen, they take patient satisfactions seriously and have patient advocates sit on their board and meet with a patient focus group quarterly where feedback is received and actions taken.

- **Treatment/Clinical**—Evergreen has demonstrated outstanding clinical outcomes using their Harm Reduction Model. They out perform state metrics in several key HIV measures including: Medication Adherence at 88%, Linkage, and retention of patients.

- **Electronic Secure Data**—Evergreen has broken the barrier with linking community action plans and treatment plans through shared care plans. Their Care Coordinators share the community data through an interface to the EMR, allowing for continuity of goal setting and barriers to treatment.

- **Patient Engagement & Population Management**—Evergreen and PCMH are focused on population health management and patient engagement being the key pieces of excellence.

- **Savings**—With HIV care, keeping the patient linked and medication adherence decreasing viral load is key to keeping the patient well and not accelerating the virus. This results in cost savings overall due to less ED care, less hospitalization and worsening of a chronic condition.
Providing the right care, to the right patient, at the right time, in the right way and being able to prove it.
QUESTIONS

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