Managing Health Outcomes Through Integrated Care

Cree Board of Health & Social Services of James Bay
Steve Tierney MD, Senior Director Quality Improvement
Thomas Mitchell RN, Senior Learning and Development Clinical Advisor

65,000 voices
Objectives

- Describe how SCF uses the integrated care teams to manage workflow and customer-owner panels
- Examine segmentation of high utilizers to optimize resources
Vision
A Native Community that enjoys physical, mental, emotional and spiritual wellness

Mission
Working together with the Native Community to achieve wellness through health and related services
Goals

Shared Responsibility
Commitment to Quality
Family Wellness
Operational Principles

**R**elationships between customer-owner, family and provider must be fostered and supported

**E**mphasis on wellness of the whole person, family and community (physical, mental, emotional and spiritual wellness)

**L**ocations convenient for customer-owners with minimal stops to get all their needs addressed

**A**ccess optimized and waiting times limited

**T**ogether with the customer-owner as an active partner

**I**ntentional whole-system design to maximize coordination and minimize duplication

**O**utcome and process measures continuously evaluated and improved

**N**ot complicated but simple and easy to use

**S**ervices financially sustainable and viable

**H**ub of the system is the family

**I**nterests of customer-owners drive the system to determine what we do and how we do it

**P**opulation-Based systems and services

**S**ervices and systems build on the strengths of Alaska Native cultures
Leadership Principles

Operate from the strength of Alaska Native cultures and traditions of leadership.

Will stand in the gap to align and achieve the mission and vision.

Nurture an environment of trust that encourages buy-in, systematic growth and change.

Encourage ownership of responsible, calculated risk taking.

Expect and grow the skills of future generations to drive initiatives and improvements.

Share and listen to personal life stories in order to be transparent and accountable.

Edges people in by creating a safe environment where spiritual, ethical and personal beliefs are honored.

Improve for the future by learning from the past, giving away credit and celebrating achievements.

Practice and encourage self-improvement believing there is good in every person.
We Asked the Community
We Changed Everything
Core Concepts

Work together in relationship to learn and grow
Encourage understanding
Listen with an open mind
Laugh and enjoy humor throughout the day
Notice the dignity and value of ourselves and others
Engage others with compassion
Share our stories and our hearts
Strive to honor and respect ourselves and others
The Philosophic Process of Redesign

- Outcome Not Income
- Person Not Disease
- Population Not Process
- Service Not Practice
## Managing the Whole Population

<table>
<thead>
<tr>
<th>Case Manager/Case Management Support/Support Clinic Data</th>
<th>Provider+ BHC/Pharm/Diet</th>
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</thead>
<tbody>
<tr>
<td>40% Of Customer-Owners Have Low Intensity Needs</td>
<td>20% Of Customer-Owners Have High Intensity Needs</td>
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<tr>
<td>Vaccines</td>
<td>Provider+ BHC/Pharm/Diet</td>
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<tr>
<td>Cancer Screenings</td>
<td>End of Life</td>
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<td>Episodic Complaints</td>
<td>High Intensity Utilizers</td>
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<td>Condition Monitoring</td>
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<tr>
<td>Acute Serious Medical Condition</td>
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</table>
Care Team Ratios

Primary Care Team

- 1 Certified Medical Assistant
- 1 Primary Care Provider
- 1 RN Case Manager
- 1 Case Manager Support

Integrated Care Clinic Team

- 2 Behavioral Health Consultants
- 1 Pharmacist
- 1 Registered Dietitian
- 1.5 Certified Nurse Midwife
- 2 Coverage Physician Assistants/Nurse Practitioners

1,100-1,400 Empaneled Customer-Owners

6 General Practice Physicians
Parallel Work Flow Redesign
Establish Benchmarks: Transparency

<table>
<thead>
<tr>
<th>Clinical Metrics</th>
<th>Clinic Score Indicator</th>
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<tbody>
<tr>
<td>Red: Less than 50th HEDIS percentile or SCF Benchmark</td>
<td>🔴</td>
</tr>
<tr>
<td>Green: Greater than or Equal to 50th HEDIS percentile or SCF Benchmark</td>
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<table>
<thead>
<tr>
<th>Clinical Measure (Click measure title for methodology)</th>
<th>Measure Score</th>
<th>Measure Goal</th>
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<td>81.45 - HEDIS 50th</td>
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<tr>
<td>Diabetes HbA1c Annual</td>
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<td>85.0 - HEDIS 50th</td>
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<tr>
<td>Diabetes HbA1c Annual Poor Control</td>
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<tr>
<td>Diabetes LDL Under 100</td>
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<td>Pediatric Diabetes HbA1c Annual</td>
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<td>Depression</td>
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<td>Pediatric BMI</td>
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<td>SBIRT</td>
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Meaningful Use Scores for Tierney, Steve J, MD

<table>
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<tr>
<th>Goal</th>
<th>Avg Score</th>
<th>Indicator</th>
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<tr>
<td>CPOE for Medication</td>
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<td>CPOE for Laboratory</td>
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<td>CPOE for Radiology</td>
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<td>Transmit Prescriptions Electronically</td>
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<td>Patient Online Access 1</td>
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<td>Transition of Care</td>
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</table>

ED Visits Per 100 Primary Care Visits

- UCL: 40.37
- Average Provider Score: 32.63
- Provider Score: 31.78
- LCL: 24.89
Centralized Data Warehouse Approach

**Inputs**
- Electronic Record
- Personal Health Record
- Wellness Application
- Socioeconomic Data
- Outside Lab and Pharmacy
- Vaccination Data Bases

**Outputs**
- Regulator Performance Reporting
- Organizational Leadership Performance Scorecard
- Workforce Scorecard
- Pattern Recognition and Risk Adjustment Modeling
# HEDIS Diabetes LDL Under 100 Scores

**HEDIS Diabetes LDL Under 100 Scores as of: 4/15/2017**

**HEDIS Medicaid Benchmark 75th Percentile = 40.39%**

<table>
<thead>
<tr>
<th>Organization</th>
<th>Clinic</th>
<th>Provider</th>
<th>Numerator</th>
<th>Denominator</th>
<th>% Screened</th>
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<tbody>
<tr>
<td>SCF</td>
<td>1 East</td>
<td>Integrated Pharmacist:</td>
<td>829</td>
<td>1843</td>
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<tr>
<td></td>
<td>1 West</td>
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<td>226</td>
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<tr>
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<td>2 East</td>
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<td>2 West</td>
<td>Integrated Pharmacist:</td>
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<td>13</td>
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<td>3 East</td>
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</table>
Breast Cancer Screening Comparison Chart (30 or More @ Risk Patients)

As of 02/25/2017
High performance is often already occurring, as are patterns of events that indicate risk.

Initiative-based improvement assumes even performance for all participants and process change is applied to all with the same expectations.

Instead of using process enforcement to drive change, identify current high performance and study approaches that already work.
Creating a Learning System

- Compare high performance with high outcome avoidance etc.
- Look for segmentation and effect

**Step 1**
Choose a condition with a process item and interval

**Step 2**
Pick a performance expectation

**Step 3**
Choose an avoidable outcome this may prevent

**Step 4**
Compare when the process is done or not done against the rate for avoidable outcomes (test impact)
# High Risk Dispensing Patterns

<table>
<thead>
<tr>
<th>Drug Category</th>
<th>Order Date</th>
<th>Date Dispensed</th>
<th>Total Qty Prescribed</th>
<th>Qty Dispensed</th>
<th>Days Supply</th>
<th>Date Supply Ends</th>
<th>Dispense Overlap Day</th>
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<tr>
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<td>120</td>
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<td>Opiate Prescriptions: 18</td>
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Total Prescriptions: 23

Benzodiazepine Prescriptions: 5

Total Qty: 1,664

MAX Consecutive Days: 106

Last Dispensed: 4/13/2016

Opiate Prescriptions: 18

Total Qty: 378

MAX Consecutive Days: 152

Last Dispensed: 5/3/2016

Benzodiazepine Qty: 378

Dispense Overlap Day: 0
# High Risk Visit Patterns Indicating Distress

<table>
<thead>
<tr>
<th>Medication Agreement</th>
<th>Inpatient Visits Last 1 Year</th>
<th>ED Visits Last 1 Year</th>
<th>UCC Visits Last 1 Year</th>
<th>Ambulatory Visits Last 1 Year</th>
<th>Specialty Visits Last 1 Year</th>
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</table>
Once you identify an indicator for increased risk or decompensation, create focused efforts around modifying the trajectory.

This refines and targets who and why you add a process, with a clear means of tracking impact of that process over time.
Using Targeted Segmentation

- Geographic location, age, gender, condition, visit numbers can offer opportunities for segmentation.
- Using labs, medications, procedures or visits that are potential indicators of distress, you can target resources and interventions.
- Examples: Nebulizer treatments, blood gas, BNP lab, cardiac enzymes, D-Dimer, admission event, A&E visits, medications like benzodiazepines or narcotics over a certain threshold indicate decompensation.
Questions?
Thank You!

Qağaasakung
Aleut

Mahsi'
Gwich’in Athabascan

Quyana
Yup’ik

T’oyaxsm
Tsimshian

Tsin'aen
Ahtna Athabascan

Quyanaa
Alutiiq

Igamsiqanaghalek
Siberian Yupik

Gunalchéesh
Tlingit

Chin’an
Dena’ina Athabascan

Quyanaq
Inupiaq

Awa’ahdah
Eyak

Háw’aa
Haida