One Organization’s Experience with Integrated Care: Increasing Care through Collaboration

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Disclosures

• We have nothing to disclose

• Except that we are incredibly passionate about the work that we do and the improvements that integrated care teams will make to your practice!
Objectives for Rural Health Integration of Care Teams

• Discuss how historical (non-integrated) vs current (integrated) approach impacts patient access to care, increased capacity and improve outcomes

• Demonstrate how collaboration increases capacity and addresses barriers to care across northern Arizona

• Showcase how layering strategies (huddles, technology & collaboration) increases ability to address health issues
North Country HealthCare (NCHC)

- Federally Qualified Health Center (FQHC)
- Serves 14 communities across rural northern Arizona
- Services offered
  - Pharmacy
  - Clinical pharmacy
  - Primary care & family practice
  - Pediatrics
  - OB/GYN
  - Dental
  - Behavioral health
  - Physical Therapy
  - Diabetes support
  - Community Health/Enabling Programs
Background (NCHC)

- Fed 330 grantee
- 340B covered entity
- 50,000 unique patients per year
- Flagstaff clinic - single largest clinic
  - (40% of patient population)
- $55 million dollar operating budget organizationally
- ~26% of budget from pharmacy services
- NCHC payer mix
  - 20% Medicare
  - 31% Commercial Insurance
  - 39% Medicaid
  - 10% Sliding Fee Scale/Uninsured

- 51% of board members required to be patients
Pre-Integrated Care Teams (ICT)

- Silo-ed efforts
  - Clinical Pharmacists (RPh)
  - Care Managers (CM)
  - Dental
  - Behavioral Health (BH)
  - Primary Care Team (PCP, MA, PRR, RN)
  - Community Health Programs (MCM, CHW, FHA, Navigators)
- Single EHR
- Fragmented patient registries and data collection in disparate systems
- No care team workflows with clear role delineation
- Inconsistent communication through “drive by” consults & warm hand-offs
- PCP required to initiate all care team involvement- no automatic defaults/triggers for ICT
Post-Integrated Care Teams (ICT)

- Dedicated Teams
- Single EHR
- Improved patient registries and data collection in disparate systems
- Tool (PVP) dedicated to ICT communication
  - Assists in role delineation
- Care team workflows with clear role delineation for high risk patients
  - Controlled Substance Workflow
  - Screening Mammogram Standing Order Workflow
  - Diabetes Workflow
  - Depression Screening and Follow-Up Workflow
- Improved communication through:
  - PVP driven huddles
  - Auto defaults and triggers within workflows for ICT involvement
- PCP no longer required to initiate all care team involvement
Roadmap to Integration

- Identify the integrated care team
- Create strategic initiatives that prioritize integration
- Complete an organizational assessment to evaluate current level of integration
- Create a roadmap with measurable metrics
- Collaboratively decide on a limited number of high risk population(s) of focus for all care team members
- Create detailed workflows detailing how each care team member will engage with the high risk population(s)
- Delineate clear roles for Care Managers and other team members
Identifying Integrated Care Team Members

- Primary Care Provider
- Medical Assistant
- Pharmacist
- Behaviorist
- Care Manager
- Physical Therapy
- Health Partners ®

- Front Operations Team
- Dental
- Family Health Advocates
- Community Health Program staff
- Support staff (billing, IT, EHR, etc)
Strategic Initiative Milestones

- Delineated 5 High Risk Populations
- Assigned workgroups for each population
- Established timeline and implemented breast cancer screening and controlled substance workflows
- High Utilizer (June)
- Delineate pediatric High Risk/Prioritized Populations
- Relaunched Depression Screening & Follow Up (January)
- Implemented Diabetes Workflow (February)
- Implemented use of PVP Tool (November)
High Risk Populations’ Connection to PCMH Standards

High Risk patients as defined by the Patient Centered Medical Home

– Poorly controlled or complex conditions
– Behavioral health conditions
– Social determinants of health
– High Utilizers of the ED/Hospitals
# Prioritized, Actionable High Risk Populations

<table>
<thead>
<tr>
<th>High Risk Population</th>
<th>Definition</th>
<th>PCMH Criteria Designation</th>
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</thead>
<tbody>
<tr>
<td>Prediabetes</td>
<td>A1C and BMI increase from baseline A1C over 9</td>
<td>Poorly Controlled/Complex Condition(s)</td>
</tr>
<tr>
<td>Diabetes</td>
<td>A1C and BMI increase from baseline A1C over 9</td>
<td>Poorly Controlled/Complex Condition(s)</td>
</tr>
<tr>
<td>Care Gaps</td>
<td>Outstanding colorectal, breast or cervical cancer screening per clinical guidelines</td>
<td>Poorly Controlled/Complex Condition(s)</td>
</tr>
<tr>
<td>Chronic Controlled Substances</td>
<td>ICD10 code indicating 90 days or more on a controlled substance</td>
<td>Behavioral Health Condition(s)</td>
</tr>
<tr>
<td>High Utilizer – Hospitalizations</td>
<td>Four or more ER or hospital stays in the last 12 months</td>
<td>High Utilizers of the ED/Hospital</td>
</tr>
<tr>
<td>Social Determinants of Health</td>
<td>Immediately qualify for high risk based on self-disclosed acuity indicators – suicide ideation per screening</td>
<td>Social Determinant(s) of Health &amp; Behavioral Health Condition(s)</td>
</tr>
</tbody>
</table>
Diabetes A1C>9 Workflow
Introducing the PVP Tool

*All the info in ONE place
*Actionable
*Mapped to OBS terms
*Drives workflows
*Chronic Dx:
  - ADHD
  - AMI
  - CAD
  - CAD-no MI
  - CO
  - CHF
  - CKD-Stg5
  - CNMP
  - COPD
  - DEP
  - DM
  - HIV
  - HTN-E
  - HTN-NE
  - HyLip
  - IVD
  - SED
  - SCZ

*Risk Factors:
  - ACT
  - ACT High ER Ut
  - Low Soc Spt
  - BMI
  - Pre-DM
  - Underimm
  - Dev Delay
  - Act Preg
  - Preg HiR
  - SMI
  - MSM
  - HDU
  - SUD
  - TOB
  - COT

*Up to 87 Alerts Available
*10 Alerts “Turned On”
Process for ICT Communication

• Provider teams (3) and ICT (3) piloted the tool for three or more months
• On-going post-implementation check-ins
• Streamlines the pre-visit prep process and huddle interaction
• Provides the basic for a snapshot of patient care opportunities to mobilize the team
• Evidence based for pre-visit process
Benefits

- Better mapped = better data
- Increased accuracy through training
- Clear role delineation
- Automatic defaults/triggers for engagement
- More actionable to a broader integrated care team
- More information in one location
PVP for Diabetes

<table>
<thead>
<tr>
<th>Diagnoses (3)</th>
<th>Alert</th>
<th>Message</th>
<th>Most Recent Date</th>
<th>Most Recent Result</th>
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<tbody>
<tr>
<td>DM</td>
<td>A1c</td>
<td>Out of Range</td>
<td>8/30/2018</td>
<td>12.3</td>
</tr>
<tr>
<td>HIV</td>
<td>Sub Use Scr</td>
<td>Missing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HyLip</td>
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<tr>
<th>Risk Factors (2)</th>
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<tbody>
<tr>
<td>DM</td>
<td></td>
<td></td>
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<tr>
<td>Pre-DM</td>
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</table>

<table>
<thead>
<tr>
<th>Diagnoses (4)</th>
<th>Alert</th>
<th>Message</th>
<th>Most Recent Date</th>
<th>Most Recent Result</th>
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<tbody>
<tr>
<td>DM</td>
<td>A1c</td>
<td>Missing</td>
<td></td>
<td></td>
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<tr>
<td>HIV</td>
<td>Sub Use Scr</td>
<td>Missing</td>
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<tr>
<th>Risk Factors (1)</th>
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<tr>
<td>DM</td>
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### PVP for Mammogram Screening

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<td>SCZ</td>
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<td>SM</td>
<td>TOB</td>
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#### Mammogram Screening

- Alert: Mammo
- Message: Missing
- Most Recent Date: 7/9/2018
- Most Recent Result: 25.62
PVP for Controlled Substances

Chronic Opioid Use
PVP for Social Determinants

Depression Screening & Follow-Up
PVP Tool Carves Out ICT Roles

- **Front Office Demographics**
- **Care Manager**
  - Alerting ICT, Care Ops, Closing care gaps
- **Behaviorist**
  - Completing screening, brief interventions and patient engagement
- **Provider**
  - Confirming ICT involvement, completing orders
- **Pharmacy**
  - Identifying patients, completing MED and MTM
- **MA**
  - Screenings, CSPMP, Mammogram order
### Impact of PVP with Huddle

#### CustomScorecards - North Country PVP Evaluation

**Non-pilot teams**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target</th>
<th>Result</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well-Child Visits 3-6 Years Old (HEDIS W34)</td>
<td>70.0%</td>
<td>68.5%</td>
<td>-2.5%</td>
</tr>
<tr>
<td>Well-Child Visits 6+ Visits (HEDIS W15)</td>
<td>70.0%</td>
<td>100.0%</td>
<td>+26.7%</td>
</tr>
<tr>
<td>Adolescent Well-Care Visits 18 to 21 Years (HEDIS AWC)</td>
<td>50.0%</td>
<td>24.1%</td>
<td>+0.3%</td>
</tr>
<tr>
<td>Adolescent Well-Care Visits 12 to 17 Years (HEDIS AWC)</td>
<td>50.0%</td>
<td>55.3%</td>
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<tr>
<td>Screening for Depression and Follow-Up Plan (NGF 0410)</td>
<td>95.0%</td>
<td>80.6%</td>
<td>-1.4%</td>
</tr>
<tr>
<td>Chlamydia Screening for Women (NGF 0033)</td>
<td>65.0%</td>
<td>47.8%</td>
<td>-4.5%</td>
</tr>
<tr>
<td>BMI Screening and Follow-Up 18-64 Years (NGF 0221 – CMS99rd4)</td>
<td>95.0%</td>
<td>81.9%</td>
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</tr>
<tr>
<td>Diabetes A1c &gt; 9 or Untested (NGF 0059)</td>
<td>25.0%</td>
<td>34.1%</td>
<td>+0.3%</td>
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<tr>
<td>Child Weight Screening / BMI / Nutritional/Physical Activity Counseling (NGF 0024 modified)</td>
<td>95.0%</td>
<td>71.4%</td>
<td>-9.5%</td>
</tr>
<tr>
<td>Colorectal Cancer Screening (NGF 0034)</td>
<td>80.0%</td>
<td>35.9%</td>
<td>-4.2%</td>
</tr>
<tr>
<td>Breast Cancer Screening Ages 50-74 (NGF 2372)</td>
<td>65.0%</td>
<td>43.8%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Cervical Cancer Screening (NGF 0032)</td>
<td>70.0%</td>
<td>46.7%</td>
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**Pilot teams**

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iTEAM Utilization (CPT Codes)
Ongoing Challenges

• Continued disparate documenting systems
  – Technology barriers
  – Duplicitous documentation requirements
  – Impedes efficient identification and communication

• Not all ICT notes reviewed timely to maximize patient care opportunities

• Transition from provider driven process slow and challenging
Takeaways

- North Country is engaging ICTs around five high risk populations
  - To streamline and standardize efforts and move the needle on prioritized populations
- Engaging the ICT is designed to distribute workload across a functional clinic team and increase provider & patient satisfaction
- Integration at NCHC has changed:
  - Organizational culture
  - Patient care
  - ICT connection, capacity and collaboration