



NORTH COUNTRY

HealthCare

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**One Organization's Experience with Integrated
Care: Increasing Care through Collaboration**

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)

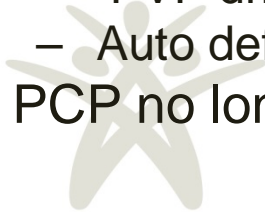
- Fed 330 grantee
- 340B covered entity
- 50,000 unique patients per year
- Flagstaff clinic - single largest clinic
 - (40% of patient population)
- \$55 million dollar operating budget organizationally
- ~ 26% of budget from pharmacy services
- NCHC payer mix
 - 20% Medicare
 - 31% Commercial Insurance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

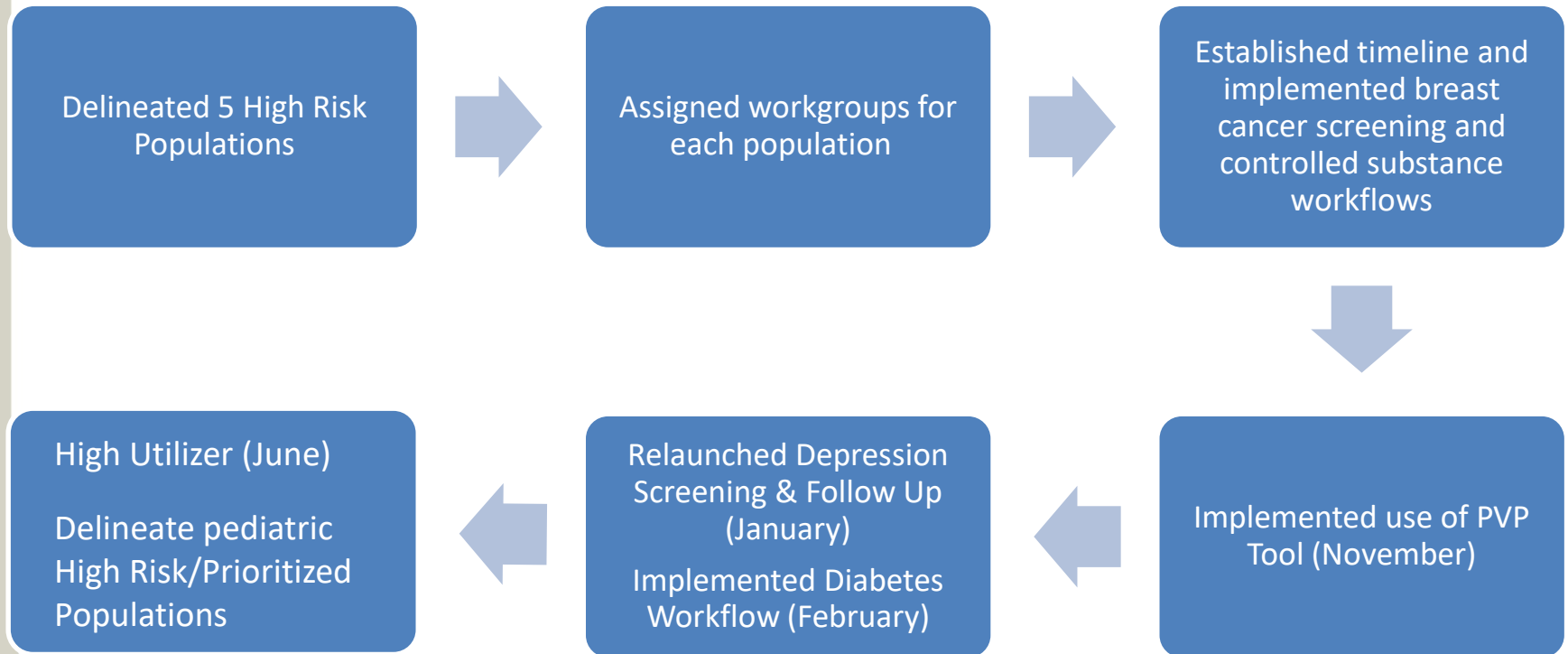
- Identify the integrated care team
- Create strategic initiatives that prioritize integration
- Complete an organizational assessment to evaluate current level of integration
- Create a roadmap with measurable metrics
- Collaboratively decide on a *limited* number of high risk population(s) of focus 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



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

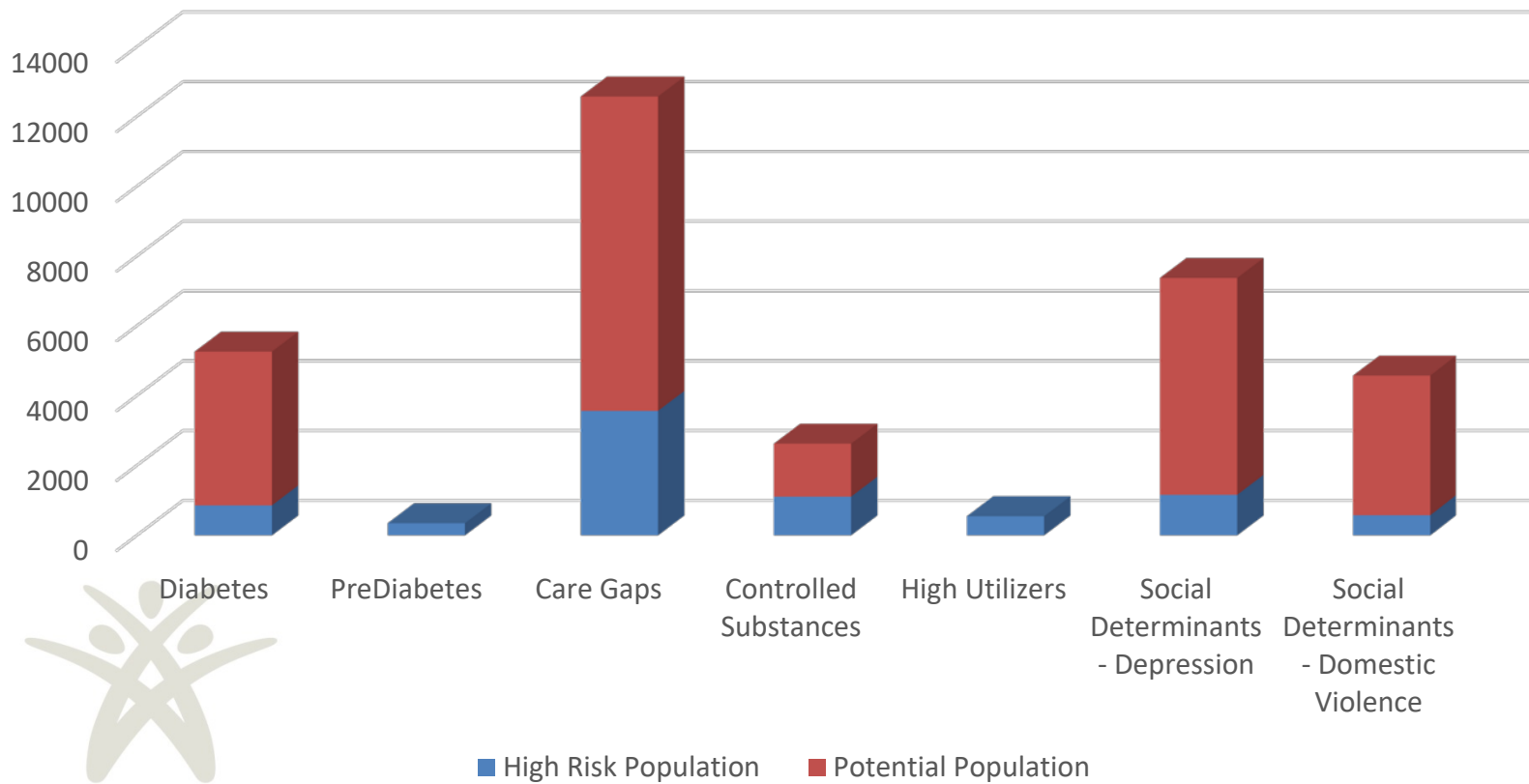


Prioritized, Actionable High Risk Populations

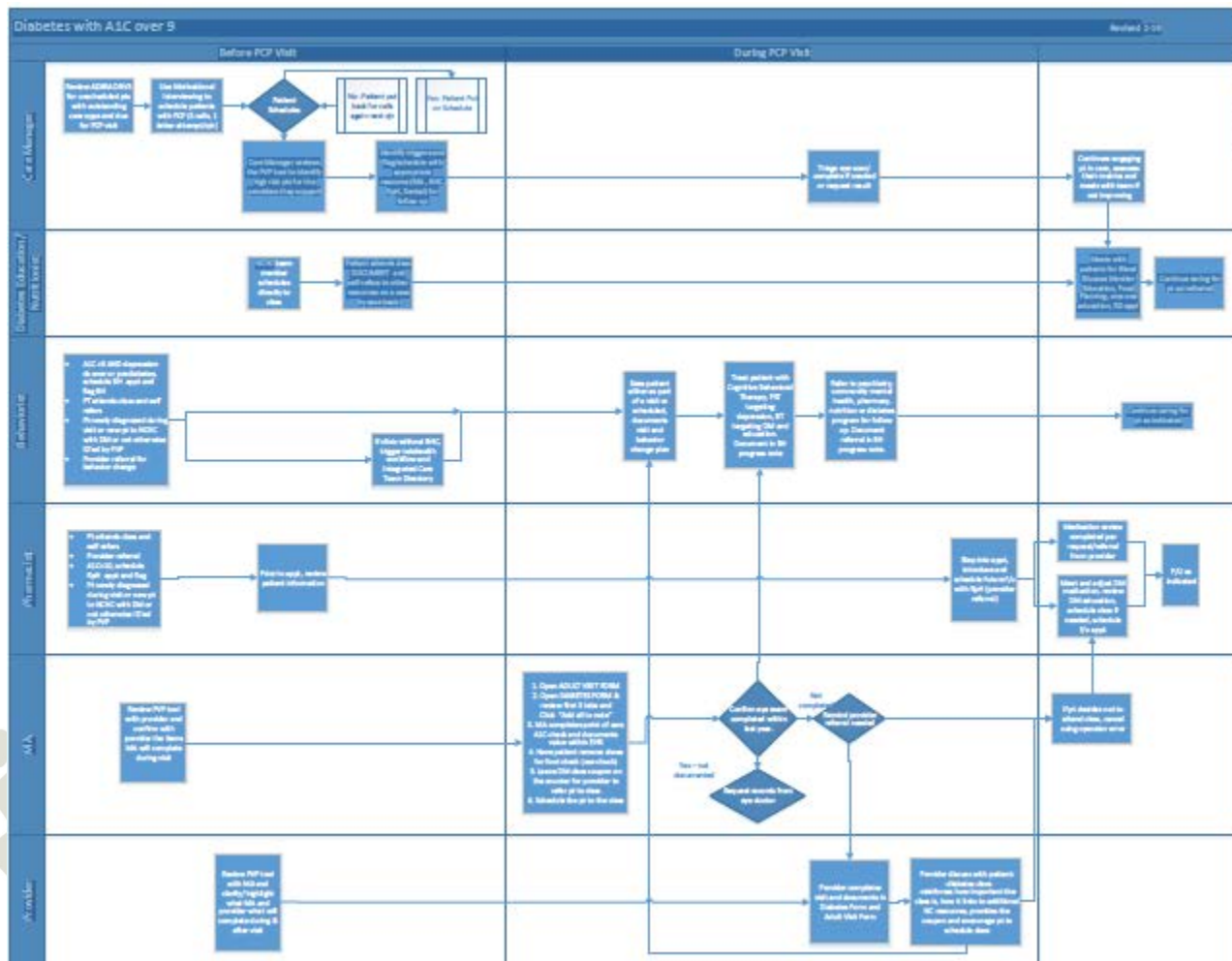
High Risk Population	Definition	PCMH Criteria Designation
Prediabetes Diabetes	A1C and BMI increase from baseline A1C over 9	Poorly Controlled/ Complex Condition(s)
Care Gaps	Outstanding colorectal, breast or cervical cancer screening per clinical guidelines	Poorly Controlled/ Complex Condition(s)
Chronic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

High Risk Population Stats – Oct 2018

Chart Title



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
- ASM
- AUT
- CAD
- CAD-no MI
- CO
- CHF
- CKD-Stg5
- CNMP
- COPD
- DEP
- DEP/BP
- DM
- HIV
- HTN-E
- HTN-NE
- HyLip
- IVD
- SED
- SCZ

*Risk Factors:

- 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"

9:00 AM Monday, October 8, 2018					Visit Reason: Established
XXXX,XXXX MRN: 298567 DOB: 2/6/1960 (58)	Sex at Birth: F Gender Identity: Female Sexual Orientation: Straight (not lesbian or gay)	Phone: (346) 225-XXXX Language: English	Last Well Visit: Portal Access: N	PCP: Abbott, Brandon Payer: APIPA UHC Medicaid Care Manager:	
Diagnoses (2)	HIV SCZ				
Risk Factors (2)	SM TOB				
		Alert	Message	Most Recent Date	Most Recent Result
		Mammo Sub Use Scr BMI & FU	Missing Missing Missing Follow-up	7/9/2018	25.62
9:30 AM Monday, October 8, 2018					Visit Reason: Established
XXXXX, XXXX MRN: 212243 DOB: 11/25/1987 (30)	Sex at Birth: M Gender Identity: Sexual Orientation:	Phone: (928) 219-XXXX Language: English	Last Well Visit: Portal Access: N	PCP: McCrosky, Stephen Payer: APIPA UHC Medicaid Care Manager:	
Diagnoses (1)	HIV				
Risk Factors (3)	HDU SUD TOB				
		Alert	Message	Most Recent Date	Most Recent Result
		Sub Use Scr	Missing		
10:30 AM Monday, October 8, 2018					Visit Reason: Established
XXXX, XXXX MRN: 156848 DOB: 11/18/1982 (35)	Sex at Birth: F Gender Identity: Female Sexual Orientation: Straight (not lesbian or gay)	Phone: (928) 219-XXXX Language: English	Last Well Visit: Portal Access: N	PCP: Raja, Rubina Payer: UMR Insurance Company Care Manager:	
Diagnoses (4)	ASM HIV CNMP HyLip				
Risk Factors (2)	TOB UnderImm				
		Alert	Message	Most Recent Date	Most Recent Result
		Sub Use Scr	Missing		

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

11:30 AM | Tuesday, October 9, 2018 **Visit Reason: Established**

XXXX, XXXX MRN: 264429 DOB: 2/22/1982 (36)	Sex at Birth: F Gender Identity: Sexual Orientation:	Phone: (951) 662-XXXX Language: Spanish	Last Well Visit: Portal Access: N	PCP: Abbott, Brandon Payer: RWCAP Mohave Care Manager:
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Diagnoses (3)

DM	HIV	HyLip
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Risk Factors (2)

BM	Pre-DM
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Alert **Message** **Most Recent Date** **Most Recent Result**

A1c	Out of Range	8/30/2018	12.3
Sub Use Scr	Missing		

1:00 PM | Tuesday, October 9, 2018 **Visit Reason: Established**

XXXX, XXXX MRN: 235399 DOB: 12/30/1952 (65)	Sex at Birth: M Gender Identity: Sexual Orientation:	Phone: (928) 855-XXXX Language: English	Last Well Visit: Portal Access: N	PCP: Raja, Rubina Payer: Medicare NAS Care Manager:
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Diagnoses (4)

DM	HTNE		
HIV	HyLip		

Risk Factors (1)

BM

Alert **Message** **Most Recent Date** **Most Recent Result**

A1c	Missing		
Sub Use Scr	Missing		

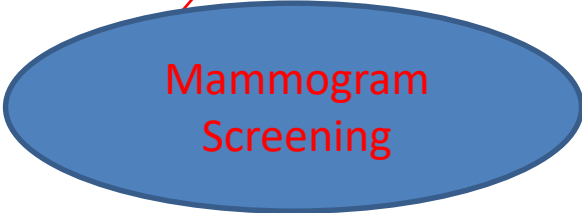
```
graph TD; Diabetes((Diabetes)) --> DM1[DM]; Diabetes --> A1c2[A1c];
```

PVP for Mammogram Screening

Abbott, Brandon

28 Scheduled Appointments

9:00 AM Monday, October 8, 2018				Visit Reason: Established		
XXXXX,XXXX MRN: 298567 DOB: 2/6/1960 (58)	Sex at Birth: F Gender Identity: Female Sexual Orientation: Straight (not lesbian or gay)	Phone: (346) 225-XXXX Language: English	Last Well Visit: Portal Access: N	PCP: Abbott, Brandon Payer: APIPA UHC Medicaid Care Manager:		
Diagnoses (2)			Alert	Message	Most Recent Date	Most Recent Result
HIV	SCZ		Mammo	Missing		
			Sub Use Scr	Missing		
			BMI & FU	Missing Follow-up	7/9/2018	25.62
Risk Factors (2)						
SM	TOB					



Mammogram
Screening



PVP for Controlled Substances

11:00 AM Monday, October 8, 2018				Visit Reason: Established 20		
XXXX, XXXX MRN: 267385 DOB: 11/28/1971 (46)	Sex at Birth: M Gender Identity: Male Sexual Orientation: Lesbian Or Gay	Phone: (928) 768-XXXX Language: English	Last Well Visit: Portal Access: N	PCP: Raja, Rubina Payer: Health Choice Integrated Care Care Manager:		
Diagnoses (2)			Alert	Message	Most Recent Date	Most Recent Result
HIV SCZ			Sub Use Scr	Missing		
Risk Factors (4)						
HDU SUD SM TOB						
11:30 AM Monday, October 8, 2018				Visit Reason: Established		
XXXX, XXXX MRN: 146723 DOB: 6/28/1971 (47)	Sex at Birth: F Gender Identity: Female Sexual Orientation: Straight (not lesbian or gay)	Phone: (661) 528-XXXX Language: English	Last Well Visit: Portal Access: N Cohorts: High Utilizers	PCP: Abbott, Brandon Payer: APIPA UHC Medicaid Care Manager:		
Diagnoses (3)			Alert	Message	Most Recent Date	Most Recent Result
CNP COPD HIV			Depr Follow-Up Sub Use Scr	Missing Follow-up Missing	9/5/2018	6.00
Risk Factors (3)						
HDU SUD TOB						

Chronic Opioid Use



PVP for Social Determinants

11:30 AM | Monday, October 8, 2018

Visit Reason: Established

XXXX, XXXX MRN: 146723 DOB: 6/28/1971 (47)	Sex at Birth: F Gender Identity: Female Sexual Orientation: Straight (not lesbian or gay)	Phone: (661) 528-XXXX Language: English	Last Well Visit: Portal Access: N Cohorts: High Utilizers	PCP: Abbott, Brandon Payer: APIPA UHC Medicaid Care Manager:
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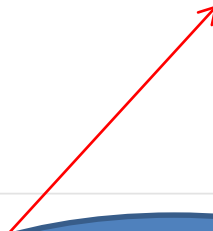
Diagnoses (3)

CNP	COPD	HIV
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Risk Factors (3)

HDU	SUD	TOB
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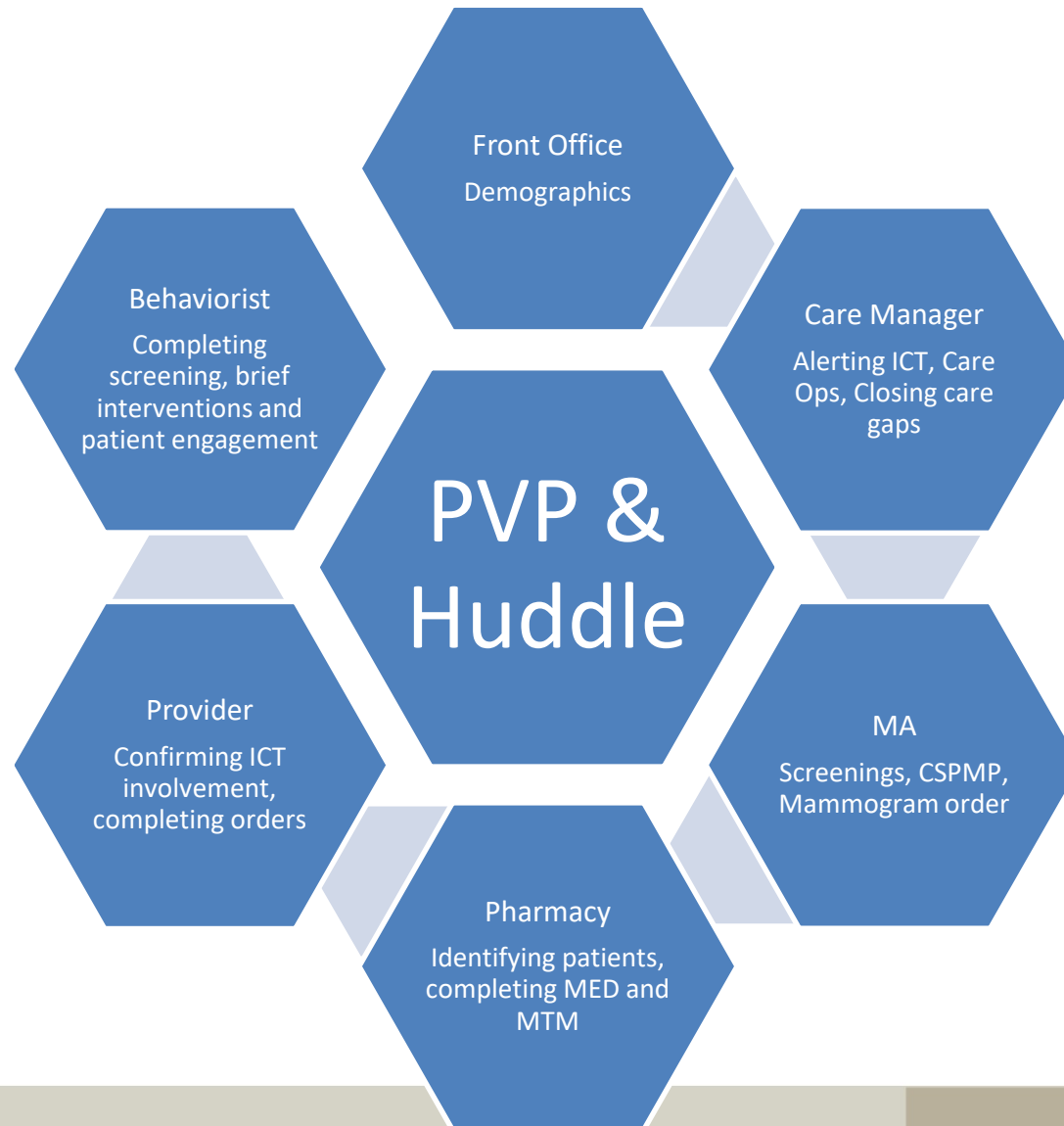
Alert	Message	Most Recent Date	Most Recent Result
Depr Follow-Up Sub Use Scr	Missing Follow-up Missing	9/5/2018	6.00



Depression Screening
& Follow-Up



PVP Tool Carves Out ICT Roles



Impact of PVP with Huddle



























CustomScorecards - North Country PVP Evaluation 

























Non-pilot teams

Pilot teams

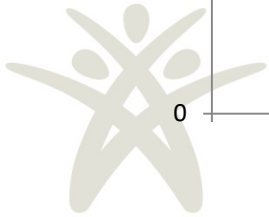
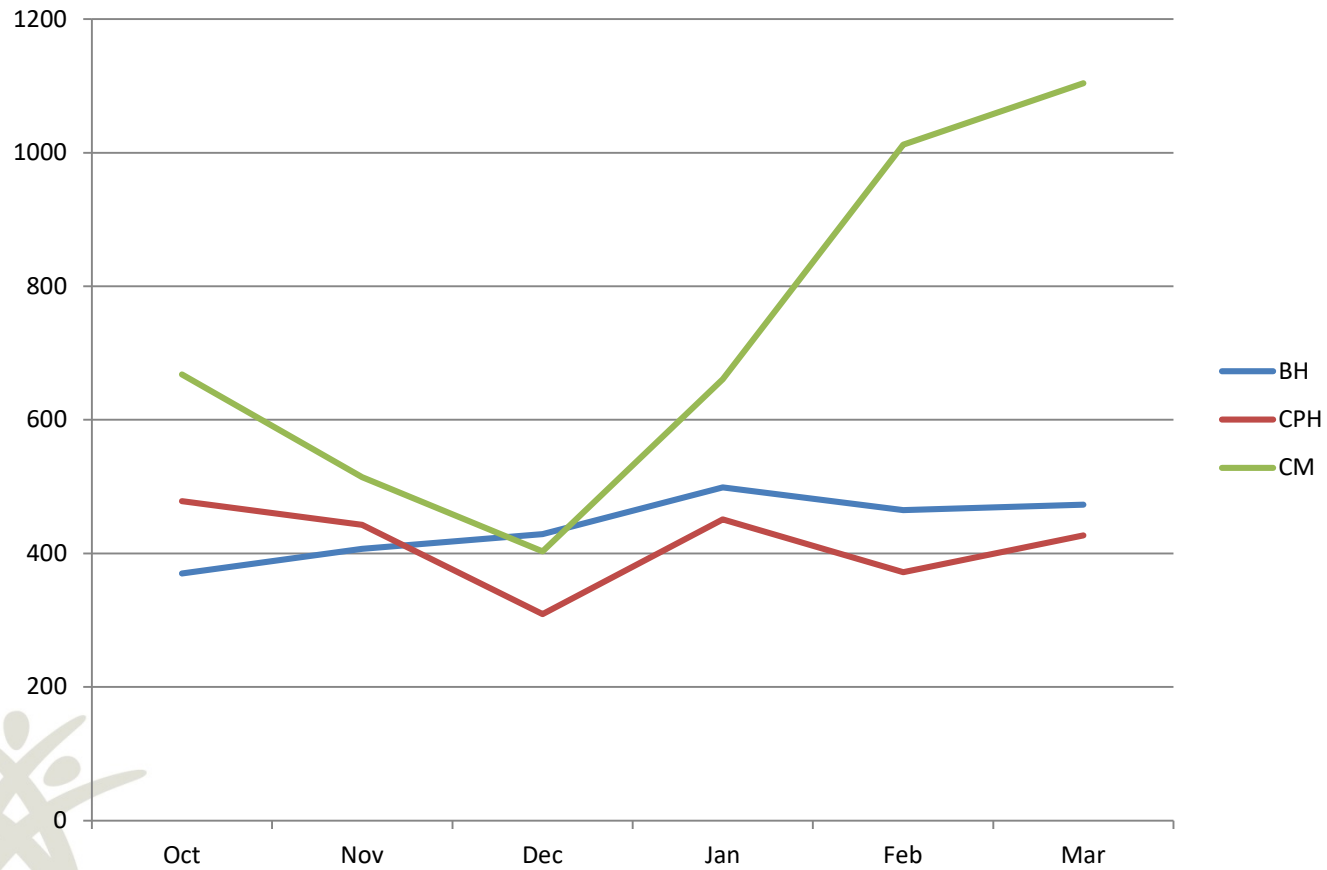
Period Type: |
 Period: |
 Providers: |
 Baseline Period: |

Period Type: |
 Period: |
 Providers: |
 Baseline Period:

		Measure	Target	Result	Change
		Well-Child Visits 3-6 Years Old (HEDIS W34)	 70.0%	68.5%	+2.8% 
		Well-Child Visits - 6+ Visits (HEDIS W15)	 70.0%	100.0%	+26.7% 
		Adolescent Well-Care Visits 18 to 21 Years (HEDIS AWC)	 50.0%	24.1%	+0.3% 
		Adolescent Well-Care Visits 12 to 17 Years (HEDIS AWC)	 50.0%	55.3%	-2.7% 
		Screening for Depression and Follow-Up Plan (NQF 0418)	 95.0%	89.6%	-1.4% 
		Chlamydia Screening for Women (NQF 0033)	 65.0%	47.8%	-4.9% 
		BMI Screening and Follow-Up 18-64 Years (NQF 0421 - CMS69v4)	 95.0%	81.9%	+0.6% 
		Diabetes A1c > 9 or Untested (NQF 0059)	 25.0%	34.1%	+0.3% 
		Child Weight Screening / BMI / Nutritional / Physical Activity Counseling (NQF 0024 modified)	 95.0%	71.4%	-0.5% 
		Colorectal Cancer Screening (NQF 0034)	 80.0%	35.9%	-0.2% 
		Breast Cancer Screening Ages 50-74 (NQF 2372)	 65.0%	43.8%	0.0%
		Cervical Cancer Screening (NQF 0032)	 70.0%	46.7%	-1.2% 

		Target	Result	Change
		70.0%	83.1%	+7.3% 
		70.0%	100.0%	+66.7% 
		50.0%	21.1%	-3.9% 
		50.0%	64.9%	+0.5% 
		95.0%	90.9%	+1.5% 
		65.0%	27.3%	+13.0% 
		95.0%	89.7%	+10.9% 
		25.0%	25.3%	-3.9% 
		95.0%	83.1%	+6.3% 
		80.0%	37.5%	+4.3% 
		65.0%	57.3%	+10.6% 
		70.0%	50.7%	+8.5% 

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