Leveraging Data to Improve Care Coordination and Quality Outcomes

Linda Wendt, Executive Director of Quality
Candice Woods, Quality Performance Analyst
Key Deliverables

• Learn how to engage leadership, staff, and providers in building a quality and care coordination performance platform.
• Learn about utilizing the data to drive improved performance.
• Understand the connection between Patient Centered Medical Home, care coordination, and quality outcomes.
System Strategy

Long-Term Strategic Plan

Continue to reposition UnityPoint Health from a hospital-centric, episodic delivery model to a physician-led, patient-centered integrated care system.

Mission

Vision

Strategic Pillars & Supporting Goals

**Best Outcome Every Patient Every Time**

- **Care Coordination**: A value-based care delivery system, providing the highest quality care in a highly coordinated effort across the continuum.
- **Physician Alignment**: A physician-led organization that attracts physicians, strengthens alignment and improves patient-centered care.
- **Employee Engagement and Excellence**: Build a sustainable culture of excellence that attracts, engages and develops high-performing individuals focusing on delivering the vision.
- **System Sustainability**: Ensure financial viability through a culture of financial discipline and adoption of best practices in both critical patient care and business processes.

Improve the health of the people and the communities we serve.
Our Brand Promise: Coordinated Care
Ron's True Story
Changing landscape of healthcare...

Medicare Shared Savings Program Accountable Care Organizations (ACOs)

For more information: www.cms.gov/sharedsavingsprogram/

November 2011
Physician-driven governance and leadership structure for UPC

• Physician/admin dyads throughout all levels
Performance Compensation Plan

• Four to Five components
  – Financial
  – Citizenship (providers only)
  – Patient Experience
  – Quality
    • Core Set for specialties (Pop. Health metrics)
  – Care Coordination
How the Performance Compensation Plan works

Funds received from the shared savings programs and other programs fund our Performance Compensation Plan.

Performance Compensation Plan

- ACO
- Payer Programs
- Government Programs
Clinical Quality Assurance Committee

- Physician leaders from across organization: identify, develop, monitor quality metrics
  - Practicing physicians from various specialties and regions
Metric Selection

• Evaluation and selection occurs yearly
  – Primary Care and Specialty specific metrics
  – Patient Experience and care coordination metrics

• Clinical guidelines/best practices

• Alignment with payer contracts

• Alignment with organizational priorities

• Input gathered from yearly Physician and AP survey
Quality/Care Coordination Metrics

- Quality/Care Coordination
  - Primary Care
    - Chronic disease
    - Preventive Screening, Immunizations, Visits
    - All Cause Readmissions
    - Follow up visits post discharge
  - Specialties
    - Specialty specific metrics
    - Core set - Population Health metrics

- Patient Experience
  - CGCAHPS (Clinician and Group-Consumer Assessment of Healthcare Providers and Systems): Four domains
Using data to improve patient outcomes
Keys steps

- Documenting in EHR
  - Finding a way to document quality metric requirements in discrete fields
  - If necessary, build new EHR fields
  - Training staff on new workflows
Key Steps cont.

• Building reports
  – Working with Analytics department to leverage the EHR data

• Validating reports
  – Extensive validation to ensure accuracy before sharing reports with Clinical Staff
Levels of reports and frequency

• Performance Scorecard (Analytics)
  – Provider
  – Clinic
  – Region
  – Organization
  – Quarterly

• Real-time Reports (Epic)
  – On demand for provider reports
Quality report – screen shot

<table>
<thead>
<tr>
<th>Measure</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Percent</th>
<th>Goal</th>
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</thead>
<tbody>
<tr>
<td>Breast Cancer Screening</td>
<td>277</td>
<td>326</td>
<td>85.0%</td>
<td>75.0%</td>
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<tr>
<td>Colorectal Cancer Screening</td>
<td>471</td>
<td>685</td>
<td>68.8%</td>
<td>68.0%</td>
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<tr>
<td>Diabetes: BP Control &lt; 140/90</td>
<td>116</td>
<td>132</td>
<td>87.9%</td>
<td>72.0%</td>
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<tr>
<td>Diabetes: HgA1C Control &lt; 8%</td>
<td>99</td>
<td>132</td>
<td>75.0%</td>
<td>70.0%</td>
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</table>
Clinic Engagement

• Clinic staff
  – Outside of the visit:
    • Care Opportunity Reports (in the EMR)
  – Pre-visit
    • Chart prep
    • Patient Summary Report
  – During the visit
Clinic Staff – Outside of the visit

• Care Opportunity reports
  – Available on demand
  – Real time data from EHR discrete fields
  – Providers and staff monitor success/opportunities
Performance Compensation Quality Measures - Diabetes: HgA1C Control < 8%

Region selected:
Department IDs selected:
Provider IDs selected:

Date Range: 05/12/2014 to 05/11/2015

<table>
<thead>
<tr>
<th>PROVIDER</th>
<th>MRN</th>
<th>PATIENT NAME</th>
<th>DOB</th>
<th>PHONE</th>
<th>METRIC</th>
<th>LAST HgA1c</th>
<th>LAST HgA1c DT</th>
<th>PAYOR NAME</th>
<th>LAST ENC DT</th>
<th>MET YN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td>Diabetes: HgA1C Control &lt; 8%</td>
<td>8.7</td>
<td>2/18/2015</td>
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<td></td>
<td></td>
<td></td>
<td>Diabetes: HgA1C Control &lt; 8%</td>
<td>12.1</td>
<td>4/10/2015</td>
<td></td>
<td>4/10/2015</td>
<td>N</td>
</tr>
</tbody>
</table>

94 met of 130 patients - 72.31%
Care Opportunity report

Example Metrics – HgA1c <8%

• Not met:
  – No recent HgA1c
  – HgA1c value >8%

• Met:
  – HgA1c value <8%
  (can be used to identify patient who will be due for a HgA1c soon)
Clinic Staff – Pre-visit

- Chart prep
  - Staff complete prior to visit
  - Allows better capture of care gaps

<table>
<thead>
<tr>
<th>Name:</th>
<th>DOB:</th>
<th>Age:</th>
<th>Sex: M or F</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appt Date:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnosis of:</th>
<th>Diabetes or Hypertension</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mammogram Date:</td>
<td>(Age 40-75 every 2 years)</td>
</tr>
<tr>
<td>Colonoscopy Date:</td>
<td>(Age 50-75 every 10 years) Or FOBT Date:</td>
</tr>
<tr>
<td>Cervical Cancer Screening/PAP:</td>
<td>(Age 21-65 every 3 years unless abnormal or hysterectomy)</td>
</tr>
<tr>
<td>Bone Density:</td>
<td>(Age 55+ or postmenopausal every 2 years)</td>
</tr>
<tr>
<td>Immunizations:</td>
<td>Influenza:</td>
</tr>
<tr>
<td>Pneumonia:</td>
<td>(PCV13 once after age 65, may have PPSV 6-12 months following PCV13. If already had PPSV, may follow with PCV13 1 year later)</td>
</tr>
</tbody>
</table>

| A1C Date: | (DM only, every 3 months) |
| Result: | (Needs to be <8%) |
| Smoker (for age 13 and older): | Yes | No |
| (If yes offer smoking cessation) |
| BMI: | 18-64 >= 25 or <18.5  65+ >= 30 or <22 |
| Overdue orders: |
| Advanced Directives (on file in Epic): |
Clinic Staff – Pre-visit

- Patient Scorecard – Summary of metrics
  – Utilizes data from several EHRs and claims data
Clinic Staff - During the visit

• Rooming standards
  – Allergies, Medications, Medical History, Fall Risk, Depression, Vitals
    (Vitals – take blood pressure last)
  – Health Maintenance review
    • Build to ask about Quality Metrics, MU, etc
UnityPoint Clinic- Quality Improvement

Diabetes A1C < 8%
• Jan 2012  61.4%  13,230 patients
• Dec 2014  69.4%  18,099 patients

Hypertension BP Control < 140/90
• Jan 2012  73.3%  53,301 patients
• Dec 2014  82.5%  71,178 patients
# UnityPoint Clinic - Quality Improvement

## Breast Cancer Screening

<table>
<thead>
<tr>
<th>Month</th>
<th>Percentage</th>
<th>Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan 2012</td>
<td>20.1%</td>
<td>(20,897 patients)</td>
</tr>
<tr>
<td>Mar 2012</td>
<td>52.7%</td>
<td>(28,463 patients)</td>
</tr>
<tr>
<td>Dec 2012</td>
<td>62.4%</td>
<td></td>
</tr>
<tr>
<td>Dec 2013</td>
<td>73.4%</td>
<td></td>
</tr>
<tr>
<td>Dec 2014</td>
<td>75.0%</td>
<td>(42,203 patients)</td>
</tr>
</tbody>
</table>

## Colorectal Cancer Screening

<table>
<thead>
<tr>
<th>Month</th>
<th>Percentage</th>
<th>Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan 2012</td>
<td>39.1%</td>
<td>(43,428 patients)</td>
</tr>
<tr>
<td>Dec 2012</td>
<td>58.9%</td>
<td></td>
</tr>
<tr>
<td>Dec 2013</td>
<td>69.1%</td>
<td></td>
</tr>
<tr>
<td>Dec 2014</td>
<td>73.9%</td>
<td>(72,136 patients)</td>
</tr>
</tbody>
</table>
Patient-Centered Medical Home

Primary Care

Team-Based

Access and Communication

Care Coordinator

Data and Metrics

Care Protocols
Patient-Centered Medical Home

2013
- 20 PCMH sites fully deployed
- 6 PCMH sites achieved NCQA Level 3 recognition

2014
- 34 PCMH sites deployed
- 27 PCMH sites achieved NCQA Level 3 recognition

2015
- 30 PCMH sites to be deployed
- 11 PCMH sites have achieved NCQA Level 3 recognition

44 total to date
Population Health Management

5% of patients
- Complex chronic conditions, comorbidities
- Care navigators
- Chronic care coordination
- Wraparound services

15%-35% of patients
- May have conditions not under control
- Patient-Centered Medical Home
- Care coordinators

60%-80% of patients
- Minor conditions, easily managed
- Low-acuity access, education
- E-health
The People of the Populations

Low Risk
- Low acuity
- Busy, active lifestyle
- Opt for convenience
- Access after hours
- Web-based communication
- E-visits

Rising Risk
- Managing chronic conditions
- Multiple medications
- Self management
- Wants to remain active

High Risk
- COPD, heart failure, depression
- Multiple medications
- Limited activity
- Lives alone
- ER, hospitalizations
Rising-Risk Priorities

Patient-Centered Medical Home

• The primary care model of UnityPoint Clinic
• The care coordination platform of UnityPoint Health
RN Care Coordinator’s role

• Utilizes registries to identify rising risk patients in need of more 1:1 engagement
  – Coaching patient towards self-management
  – Motivational interviewing with patient centered goals
  – Care Coordination
### Diabetes Management

#### Hemoglobin A1c <8

<table>
<thead>
<tr>
<th>Location</th>
<th>Jan-14</th>
<th>Dec-14</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>CI: FM-East Des Moines</td>
<td>60.9%</td>
<td>76.3%</td>
<td>70%</td>
</tr>
<tr>
<td>CR: FM-Mt Vernon</td>
<td>61.8%</td>
<td>70.0%</td>
<td>70%</td>
</tr>
<tr>
<td>QC: IM-Moline</td>
<td>62.3%</td>
<td>77.4%</td>
<td>70%</td>
</tr>
<tr>
<td>WL: FM-United Medical Park</td>
<td>78.3%</td>
<td>87.6%</td>
<td>70%</td>
</tr>
</tbody>
</table>

**% Patients w/ Hemoglobin A1c <8**
Transitional Care Management

Code released by CMS Jan 2013

- Pilot April 2013: 17 patients
- By Dec 2013: 3,349 patients
- By Dec 2014: 6,427 patients

2014 TCM Study
Inpatient Stays from 12/1/2013 - 11/30/2014
With TCM Codes 29-31 Days Following IP Discharge Date

<table>
<thead>
<tr>
<th>Admission Count</th>
<th>All Cause Readm Count</th>
<th>All Cause Readm Rate</th>
<th>% IP with TMC follow-up</th>
<th>Pts w TCM All Cause Readmissions</th>
<th>TCM Readm Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grand Total</td>
<td>31266</td>
<td>4915</td>
<td>15.7%</td>
<td>7.5%</td>
<td>202</td>
</tr>
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UnityPoint Clinic
Quality Team

• Project Managers in each region
  – Monitor clinic performance
  – Identify process opportunities
  – Compile performance comparison to compare clinics across a region
    • Learn from high performers
    • Engage and work to improve low performance
Quarterly Summary Report

Quarter 4 - 2014 Performance Report

Family Medicine

<table>
<thead>
<tr>
<th>Measure</th>
<th>Goal</th>
<th>Met?</th>
<th>Num</th>
<th>Den</th>
<th>Percent</th>
<th>Goal</th>
<th>Performance Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Measures</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast Cancer Screening</td>
<td>MET</td>
<td>370</td>
<td>464</td>
<td></td>
<td>79.7%</td>
<td>&gt;=72.0%</td>
<td></td>
</tr>
<tr>
<td>Diabetes HgA1c&lt;8%</td>
<td>MET</td>
<td>212</td>
<td>278</td>
<td></td>
<td>76.3%</td>
<td>&gt;=70.0%</td>
<td></td>
</tr>
<tr>
<td>Hypertension BP&lt;140/90</td>
<td>MET</td>
<td>701</td>
<td>824</td>
<td></td>
<td>85.1%</td>
<td>&gt;=80.0%</td>
<td></td>
</tr>
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</table>

Quality Measures - Section Summary

Measure(s) Met: 7
Percent of Measure(s) Met: 100.00%
Section Score Weight: 35%
Measure(s): 7
Section Weighted Percent: 35.00%
System level

• Marketing and Communications
  – Screenings & Immunization Campaign
    • Reminder mailing designed to engage patients using healthcare-specific predictive models to create profiles based on identified care needs for given populations
• Go try this at home
  – Burning platform
  – Leadership
  – Engagement at all levels
  – Change management
  – Process improvement leading to performance improvement
Questions?
Contact Info

Linda Wendt
Executive Director of Quality
Linda.Wendt@unitypoint.org

Candice Woods
Senior Project Management/Quality Performance Analyst
Candice.Woods@unitypoint.org