A Showcase of Health Center Achievements
Agenda

✓ Welcome
✓ A Message From CMS
✓ Health Center Achievements
✓ Exemplary Practices
✓ Showcasing Generations Family Health Center
✓ Showcasing Staywell Health Center
Lieutenant Commander Fred Butler Jr.

A Message from CMS
Radar Diagrams

- Reduction in ED/Inpatient Utilization
- Reduction Testing/Procedures
- Cost Savings
- Clinical Outcomes
- Transformation (Out of Phase 2)
- Enrollment
Reduction in ED/Inpatient Utilization

Transformation (Out of Phase 2)

Reduction Testing/Procedures

Clinical Outcomes

Cost Savings

Enrollment
Reduction in ED/Inpatient Utilization

Transformation (Out of Phase 2)

Clinical Outcomes

Enrollment

Cost Savings

Reduction Testing/Procedures
<table>
<thead>
<tr>
<th>PTN</th>
<th>Hospitalizations reduced/ clinician</th>
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<tbody>
<tr>
<td>UMass</td>
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</tr>
<tr>
<td>AZHEC</td>
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<tr>
<td>CHCACT</td>
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<tr>
<td>APA2</td>
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<tr>
<td>LA</td>
<td>-</td>
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<tr>
<td>VHS</td>
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<tr>
<td>TOTAL</td>
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**AIM 3**
Reducing Unnecessary Hospital Admissions & Utilization

**AIM 4**
Generate savings to the federal government & commercial payers

**Leader in TCPi**

- CHCACT: 12.9 hospital utilizations per clinician
- CHCACT: $43,962 saved per clinician
- TOTAL: 20,755
Q11: Asthmatics Prescribed Control Medication

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<tr>
<th>Location</th>
<th>Percentage</th>
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<tr>
<td>Generations</td>
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<tr>
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<td>83%</td>
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<td>83%</td>
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</table>
Q11: Diabetes Composite
A1c < 8.0, BP < 140/90, LDL < 100

Staywell: 44%
InterCommunity: 40%
CHS: 35%
First Choice: 30%
Southwest: 29%
Generations: 27%
Chart Oak: 25%
Fair Haven: 25%
A: 24%
B: 22%
C: 20%
D: 20%
E: 18%
F: 18%
G: 18%
H: 3%
Transformation Story:
How CT Health Centers Met CMS Commitments
Accelerate Transformation by January 2019

10,000 exemplary practices by December of 2018

How are we going to make this happen?

Exemplary Practices

2015

Aug 2018

Dec 2018

1,000

10,000!
Practice Transformation Network
Exemplary Practice

Attributes:
✓ Leadership & team commitment
✓ Culture of Quality Improvement
✓ Data drives improvement
✓ Shares Best Practices
Practice Transformation Network
Exemplary Practice

Criteria:

✓ Risk stratification model, interventions applied to high risk patients
✓ Care Team roles defined
✓ Formal process for hospital follow-up
✓ Regular multidisciplinary team meetings
✓ Organization-wide engagement in improvements identified and implemented
✓ Data shared transparently for action
Practice Transformation Network
Exemplary Practice

Evidence:

✓ Advancement through PTN Phases
✓ Sustained improvement in PTN Clinical Outcomes
✓ Reduction in Inpatient Hospital Admissions
✓ Reduction in ED Admissions
✓ Reduction in per member, per month Total Cost of Care
<table>
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<th>Category</th>
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<tr>
<td>Number of Specialty Care Practice Sites</td>
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<tr>
<td>Specialties Assessed</td>
<td>Behavioral Health</td>
</tr>
<tr>
<td>Number of Primary Care Clinicians</td>
<td>27</td>
</tr>
<tr>
<td>Number of Specialty Care Clinicians</td>
<td>14</td>
</tr>
<tr>
<td>Number of Patients</td>
<td>21,775</td>
</tr>
<tr>
<td>Percent Medicaid/CHIP</td>
<td>57.2%</td>
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<tr>
<td>Percent Medicare</td>
<td>11.5%</td>
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<tr>
<td>Percent Uninsured</td>
<td>8.8%</td>
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<tr>
<td>Rural/Urban</td>
<td>Rural</td>
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</table>
Vision: To strive to provide access to quality health care that is patient-focused in delivery and maximizes all available resources.

Who We Are

- # Practitioners: 4 Primary Care, 2 Specialty Care
- # Clinicians: 27 Primary Care, 14 Specialty Care
- Patient Population: 21,775
- Racial and/or Ethnic Minority: 44.0%
- Best Served in Another Language: 15.3%
- Income ≤ 200% of Federal Poverty Level: 86.5%

2017 Insurance Status

- Private: 23%
- Medicare/CHIP: 57%
- Medicaid: 11%
- Uninsured: 9%

Clinical Outcomes

Persistent Asthma Care (NQF 0036)

 Goal: 85-90%

Odds of Improvement: 15%

Optimal Diabetes Care Composite (A1C < 8.0%, LDL < 100 mg/dL, BP < 140/90 (mmHg))

Goal: 31.6%

Odds of Improvement: 37%

ED Utilization Reduction

We monitor this measure monthly. We give our asthma patients Asthma Action Plans at the appropriate literacy level.

Population Size: 596

Lives Improved: 270

ED visits by high-risk patients were going up the 6 months before we started our care coordination program (light green). Once these patients began receiving care coordination services, the number of ED visits began to go down (dark green). Overall, we have saved $785 ED visits & 324 Admissions.

Test/Procedure Reduction

We use Choosing Wisely recommendations to decrease the frequency antibodies are prescribed for UIRs. We use Rx for Vital Information to educate patients.

# of Rx saved: 42

Cost Savings

Our Per Member Per Month medical costs for Medicaid members have seen a 14% reduction since joining the Practice Transformation Network.

Our population’s ACG risk score is higher than 75% of health centers in CT, but we have still been able to impact the cost of care for these patients by addressing social determinants of health, chronic conditions, and care transitions among various health care settings.

References

1. 2017 LOS Data
2. CT-PTM Metrics
3. Medicaid Claims Data

Cost Savings: Medicaid Medical Per Member Per Month Costs

Patient Ping Launched:
April 2018

Care Coordinators Launch SDOH
Feb 2018

We built mobile-based tools to increase the level of engagement of our patients. These tools have allowed us to provide our patients with transportation and food needs. They have also resulted in improved outcomes for our patients.

Care Coordination Program
July 2017

We provide care coordination services to our HCC patients. These services include: follow-up visits, medication management, and more.

Expanded Saturday Hours
Jan 2017

We extended our medical access to patients who use our provider on Saturday mornings.

Care Coordination Program
Jul 2017

We provide care coordination services to our HCC patients. These services include: follow-up visits, medication management, and more.

Patient Population Risk Stratified
May 2017

We created a tool to use AQR, to identify those at risk of our patients.

Integrated Care Team Meetings
May 2017

Our Federal & Behavioral health teams meet regularly to discuss & act on patient care needs.

POS+ Wave 1
Jan 2017

We were selected to participate in AQR’s POS+ Program, which provides additional funds to launch care coordination.

Patient Wait Time EOLDA
April 2016

We used Lean improvement to decrease patient wait time using risk. The median staff productivity & patient satisfaction.

Baseline PAT
Feb 2016

Funding Source

Generations Family Health Center is a Federally Qualified Health Center and receives grant funding from HRSA, Health Resources and Services Administration, and the U.S. Department of Health and Human Services.
Monthly Quality Improvement Report
Q2 Generations UDS 2018
Tobacco Use
Colorectal Cancer Screening
Ab1C Good Control
Colorectal Cancer Screening

Goal 61%

Y/E: 12/31/2017
Period Ending: Q1 2018
Period Ending: Q2 2018
Period Ending: 7/31/2018
PQM-2: Diabetes HbA1c Good Control

Goal 80%
Vision: To strive to provide access to quality health care that is patient-focused in delivery and maximizes all available resources.

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Our Mission & Values

Mission: The mission of Generations Family Health Center, Inc. is to provide quality, compassionate and professional health care that is affordable, easily accessible and without discrimination to all members of the communities we serve.

Values:
1. We believe every individual has the right to quality health care that is respectful and considerate.
2. We are committed to providing continuity of care throughout our entire health care system.
3. We create an atmosphere for patients and staff that is safe, accessible, and free of discrimination.
4. We believe in the continuous improvement of our staff and health center systems to provide the highest quality of care to our patients.

Who We Are

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Clinical Outcomes

Persistent Asthma Care (NQF 0036)
Goal: 80-85%

<table>
<thead>
<tr>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Q5</th>
<th>Q6</th>
<th>Q7</th>
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We monitor this measure monthly. We give our asthma patients Asthma Action Plans at the appropriate literacy level.

Population Size: 599 Lives Improved: 270

Optimal Diabetes Care Composite
(A1c ≤ 8.9%, LDL < 100 mg/dL, BP < 140/90 (mmHg))

<table>
<thead>
<tr>
<th>Q1</th>
<th>Q2</th>
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<th>Q4</th>
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We give our patients with diabetes personalized care plans to engage them in the management of their diabetes. We also do point-of-care A1c and LDL tests to increase testing compliance.

Population Size: 2,223 Lives Improved: 339

ED Utilization Reduction

ED visits for high-risk patients were going up the 6 months before we started our care coordination program (light green). Once these patients began receiving care coordination services, the number of ED visits began to go down (dark green). Overall, we have saved 578 ED visits & 334 Admissions.

Test/Procedure Reduction

We use Choosing Wisely recommendations to decrease the frequency of antibiotics are prescribed for URTIs. We use Rx for Viral Infection aids to educate patients.

# of Rx saved: 42

Cost Savings

Our Per Member Per Month medical costs for Medicaid members have seen a 14% reduction since joining the Practice Transformation Network. Our population's ACG illness score is higher than 75% of health centers in CT, but we have still been able to impact the cost of care for these patients by addressing social determinants of health, chronic conditions, and care transitions among various health care settings.

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Funding Sources

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<tbody>
<tr>
<td>Number of Primary Care Sites</td>
<td>3</td>
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<td>Behavioral Health</td>
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<tr>
<td>Number of Primary Care Clinicians</td>
<td>22</td>
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<tr>
<td>Number of Specialty Care Clinicians</td>
<td>25</td>
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<tr>
<td>Number of Patients</td>
<td>24,331</td>
</tr>
<tr>
<td>Percent Medicaid/CHIP</td>
<td>72.8%</td>
</tr>
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</table>
✓ Reduced ED visits – 1,500 less visits
✓ Reduced Inpatient – 12% less visits
✓ Reduced cost - over $27 dollars PMPM
✓ Asthma outcomes – 735 lives improved
✓ Diabetes outcomes – Over 20% improvement/258 lives improved
✓ Reduction in tests - $4,400 saved on POC tests
✓ Making time and space for huddles

✓ Having each and every staff member understand their importance in the Care Team

✓ Explaining in simple terms that our goal is healthier patients who feel better while still running a business

✓ Provider turnover
✓ Question the current state
✓ Tolerate discomfort
✓ Share accurate data transparently
✓ All about the individual, and nothing to do with the individual
✓ Remove the barriers to treatment
✓ Use tools
✓ Leverage resources
✓ Celebrate success
✓ Non-blinded results dashboard
✓ Follow clinical guidelines
✓ Staff, provider and patient education
✓ “We don’t do it that way”
Celebrate success

✓ All Staff meetings
✓ Staff awards
✓ Doctors’ Day celebration
✓ Wall of Fame
✓ Titles, promotions
Take a Stroll Down StayWell Lane...
Questions?
Phases of Transformation

With One Year Left…

Phase 1
- CIFC-Danbury
- Fair Haven
- Family Centers
- Optimus

Phase 2
- Charter Oak
- CHS
- CS Hill
- First Choice
- Norwalk
- Southwest
- Staywell
- UCFS

Phase 3
- Generations
- InterCommunity

Phase 4*
*Pending Phase 4 Site Visit

Phase 5

$10k
Year 4 Strategic Areas Of Focus

✓ Phase 5 Completion
✓ Financial Acumen
✓ Celebrating Patient & Family Engagement (PFE)
✓ Reducing Unnecessary Hospitalizations
✓ Unnecessary Tests & Procedures
✓ Build Collaboration Amongst CMOs & Medical Directors
What’s next...

Year 4 Technical Assistance

✓ Focused cohorts to accelerate performance
  • Population Management
  • Optimized Care Teams
  • Diabetes Composite Improvement

✓ Ongoing regular meetings with QIA’s
  • Monthly or bi-weekly

✓ In person peer learning sessions on best practices

✓ SAN Regional Quality Improvement Training & Project
“You can’t go back and change the beginning, but you can start where you are and change the ending.”

- CS Lewis