



COMMUNITY HEALTH ACCOUNTABLE CARE, LLC

Kate Simmons, CHAC Director
Kevin Kelley, CHAC Board Chair

ACO Transformation Meeting – GMCB – May 11, 2017

Improve the ability of our participant organizations to provide the right health care for their patients based on the **medical and social needs** of each individual patient. Remain **primary care focused** and fully support the **Patient Centered Medical Home** principles of individualized, self-directed treatment plans, an orientation toward **whole health**, and **ongoing relationships** between patients and their care teams.

CHAC Vision & Values

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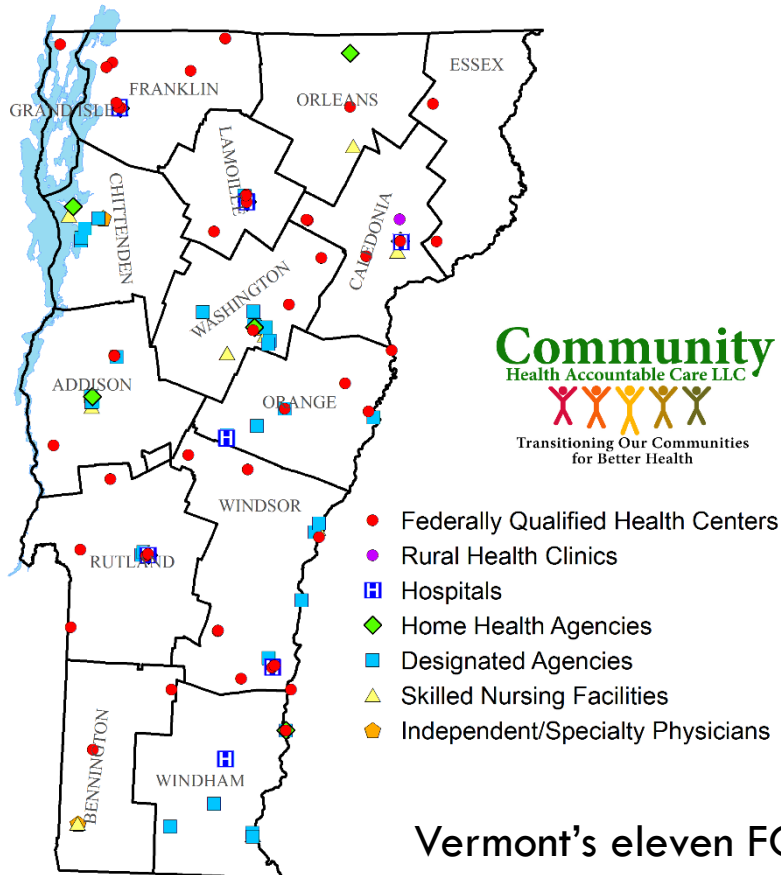
Vision: Achieve better care for individuals, better health for populations, and lower growth in expenditures in connection with both public and private payment systems.

Values: collaboration, patient centered care, shared information, measurement, accountability, and use of best clinical practices.

CHAC Network: 2017

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2017 Network



CHAC's Participant Network, 2017

- 10 Federally Qualified Health Centers
- 4 Rural Health Clinics
- 7 Hospitals
- 14 Designated Agencies
- 9 Certified Home Health Agencies
- 10 Skilled Nursing Facilities
- 4 Independent Physicians/Specialists

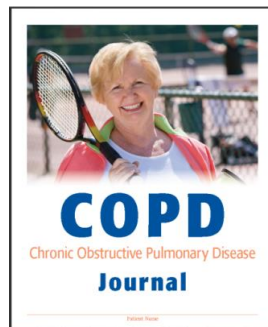
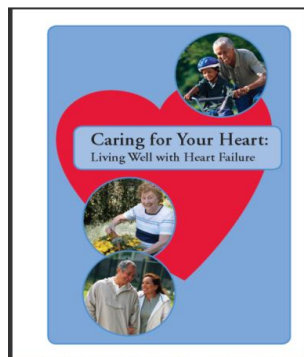
Payer Groups	2015	2016	2017
Medicaid	~20,000	~33,000	NA
Medicare	~6,400	~14,700	~21,400
Commercial	~8,900	~10,500	~15,000
Total	~35,300	~57,000	~36,400

Vermont's eleven FQHCs served over 155,000 unique patients in 2015. Four of CHAC's FQHC participants serve as lead Blueprint entities in their communities

CHAC Initiatives 2015-2017

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- Clinical Quality Improvement
- Clinical Recommendations
- Tele-Monitoring of Rising Risk Patients
- PatientPing
- Data Roadshows/Qlik
- CHAC Standards
- Capturing Clinical/Community Success Stories



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Reviewed and approved by CHAC Clinical Committee on 01.20.2015



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YOUR LOGO
HERE

[Doctor Name]

Patient Name: _____ (Sex) _____ (Age) _____

Date of Birth: ____/____/____

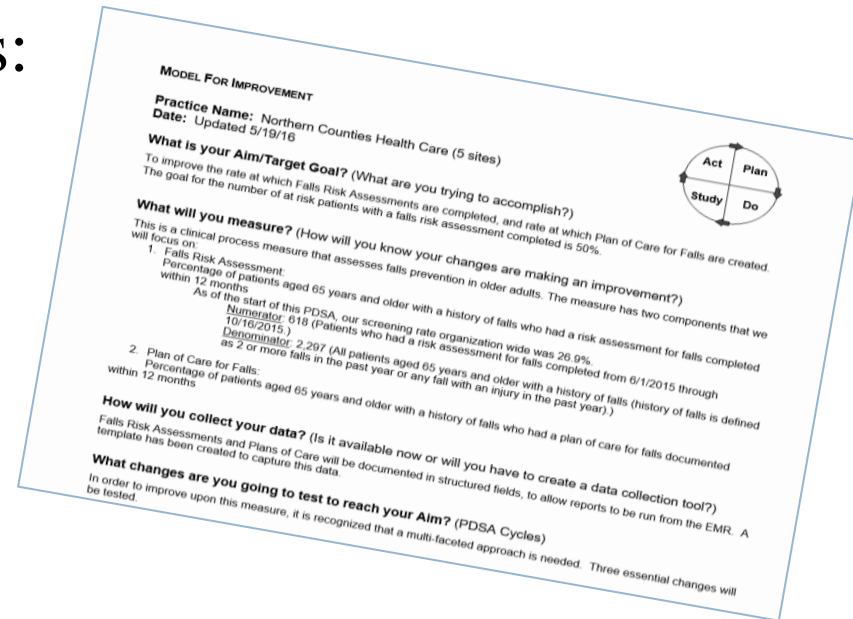
My DIABETES Action Log

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Year 2: Implementing Y1 Recommendations; Goal Setting

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- Joint Clinical and Operation Committee Meetings
- Quality Improvement Cycles:
 - Falls Risk
 - COPD
 - CHF
 - Diabetes
 - Adolescent Well-Child Visits
 - Developmental Screening
 - Chlamydia Screening
- Development of Recommendations for the Screening and Follow-Up of Patients with Depression



MODEL FOR IMPROVEMENT

Practice Name: Northern Counties Health Care (5 sites)
Date: Updated 5/19/16

What is your Aim/Target Goal? (What are you trying to accomplish?)
To improve the rate at which Falls Risk Assessments are completed, and rate at which Plan of Care for Falls are created.
The goal for the number of at risk patients with a falls risk assessment completed is 50%.

What will you measure? (How will you know your changes are making an improvement?)
This is a clinical process measure that assesses falls prevention in older adults. The measure has two components that we will focus on:
1. Falls Risk Assessment: Percentage of patients aged 65 years and older with a history of falls who had a risk assessment for falls completed within 12 months
As of the start of this PDSA, our screening rate organization wide was 26.9%.
Numerator: 618 (Patients who had a risk assessment for falls completed from 6/1/2015 through 10/16/2015.)
Denominator: 2,297 (All patients aged 65 years and older with a history of falls (history of falls is defined as 2 or more falls in the past year or any fall with an injury in the past year).)
2. Plan of Care for Falls: Percentage of patients aged 65 years and older with a history of falls who had a plan of care for falls documented within 12 months

How will you collect your data? (Is it available now or will you have to create a data collection tool?)
Falls Risk Assessments and Plans of Care will be documented in structured fields, to allow reports to be run from the EMR. A template has been created to capture this data.

What changes are you going to test to reach your Aim? (PDSA Cycles)
In order to improve upon this measure, it is recognized that a multi-faceted approach is needed. Three essential changes will be tested.

Year 3: Implementation of QI Efforts

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□ Focus Areas:

- COPD
- CHF
- Diabetes
- Adolescent Well-Child Visits
- Developmental Screening

□ Use of Trending Data to drive Quality

□ Patient Ping

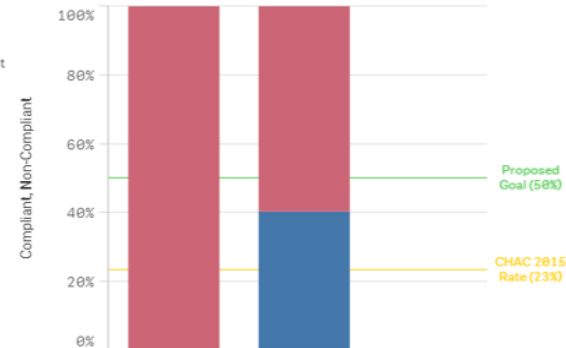
□ Trialing Data Visualization Software to understand opportunities for improvement

Health Center A:

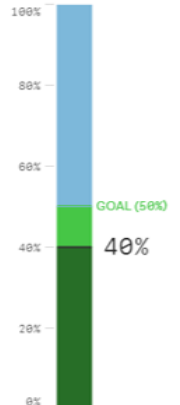
Falls Risk

Percent Screened for Falls Risk

Measures
■ Compliant
■ Non-Compliant



Compliance in 2015:



Year 4: Continuous Quality Improvement

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- Focus Areas:
 - Diabetes
 - Hypertension
 - Depression Screening
 - Colorectal Cancer Screening
- Rapid Response Data Road Shows, utilizing Data Visualization Software to identify areas for improvement
- Identification of “Promising Practices”

PatientPing and CHAC: Summary

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- ❑ CHAC Go-live Date: March 29, 2016
- ❑ Total Pings received: 58,166*
 - Includes: Admission, Transfer, Discharge, & Deceased Pings
- ❑ Total Pings on unique patient visits: 27,490
- ❑ Total facilities pinging CHAC: 84
 - 43 acute hospitals
 - 22 skilled nursing facilities
 - 18 home health agencies / VNAs
 - 1 inpatient rehab hospital

- ❑ On-site visits to all primary care participant organizations
- ❑ Trended data
- ❑ Actionable data
- ❑ Feedback on EHR documentation
- ❑ Data Visualization Tool (*Qlik*)

Data Roadshow/Screenshot

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Adult BMI by Age Group

940 Patients in **2015**

Avg BMI (Age < 65)

34.9

Avg BMI (Age 65+)

29.6

Avg BMI (All)

33.5

Plan documented (Age < 65)

77%

Plan documented (Age 65+)

52%

Plan documented (All)

73%

BMI Out of Range (Age < 65):

85%

BMI Out of Range (Age 65+):

51%

BMI Out of Range (All):

76%

934 Patients in **2014**

Avg BMI (Age < 65)

35.8

Avg BMI (Age 65+)

29.8

Avg BMI (All)

33.5

Plan documented (Age < 65)

63%

Plan documented (Age 65+)

60%

Plan documented (All)

62%

BMI Out of Range (Age < 65):

73%

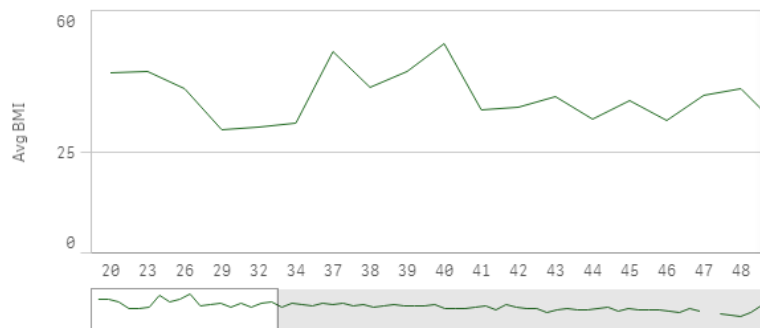
BMI Out of Range (Age 65+):

47%

BMI Out of Range (All):

65%

Average BMI by age, in 2015:



Filters:

Disposition

Payor

BMIplan

Documented

Not document...

Organi...

A

C

D

F

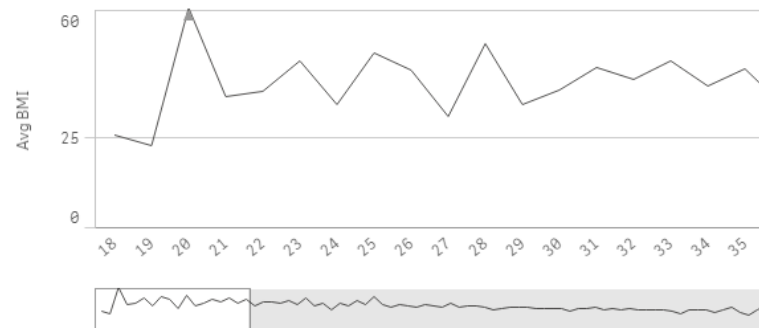
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I

J

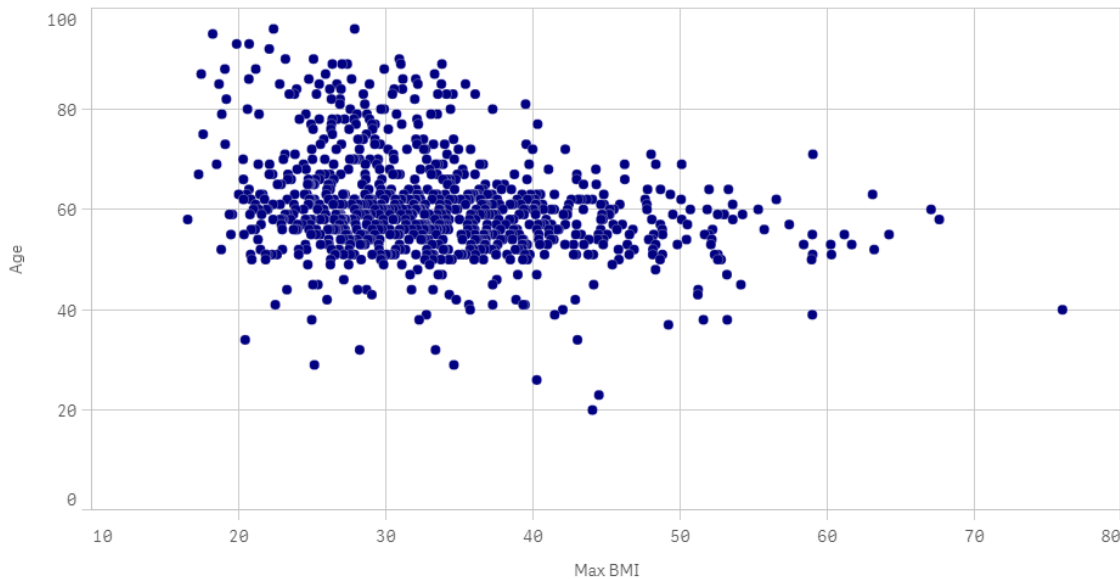
Average BMI by age, in 2014:



Data Roadshow/Screenshot

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Scatterplot: BMI by Age



Filters:

Q Disposition

- Confirmed ✓
- Pregnant
- Payor ▶

Q Data Year

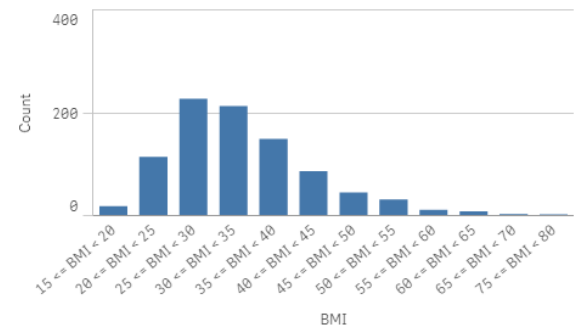
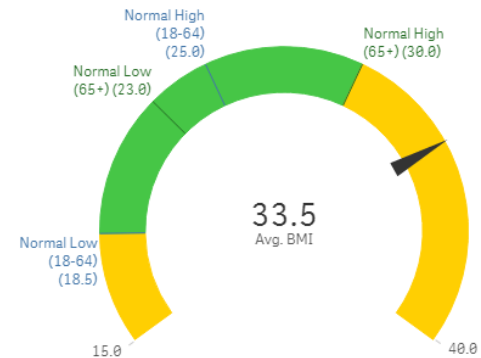
- 2015 ✓
- 2014

Q Age Group

- Age 18-35
- Age 36-64
- Age 65+
- Age 0-17

Patients:

940

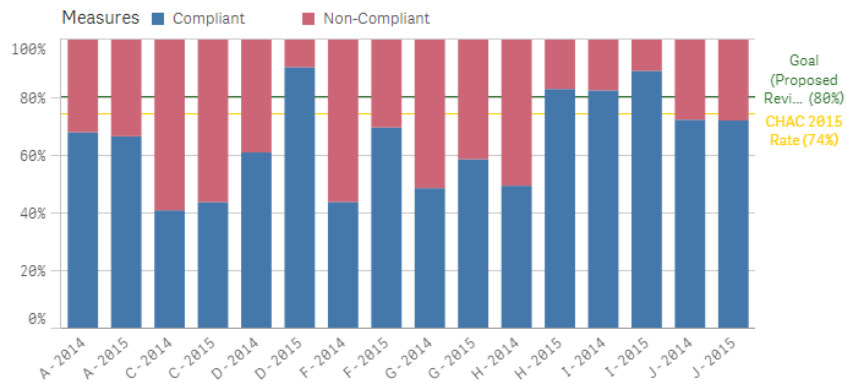


Data Roadshow/Screenshot

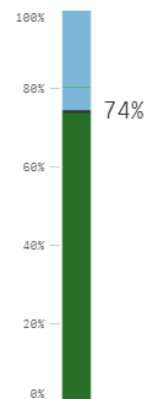
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Adult BMI

Percent Compliant for BMI Measurement and Follow-Up:



Progress Toward Goal:



940 Patients in **2015**

934 Patients in **2014**

BMI Measured:
95%

BMI Measured:
85%

BMI within Range:
20%

BMI within Range:
21%

Avg BMI (Age < 65)
34.9

Avg BMI (Age < 65)
35.8

Avg BMI (Age 65+)
29.6

Avg BMI (Age 65+)
29.8

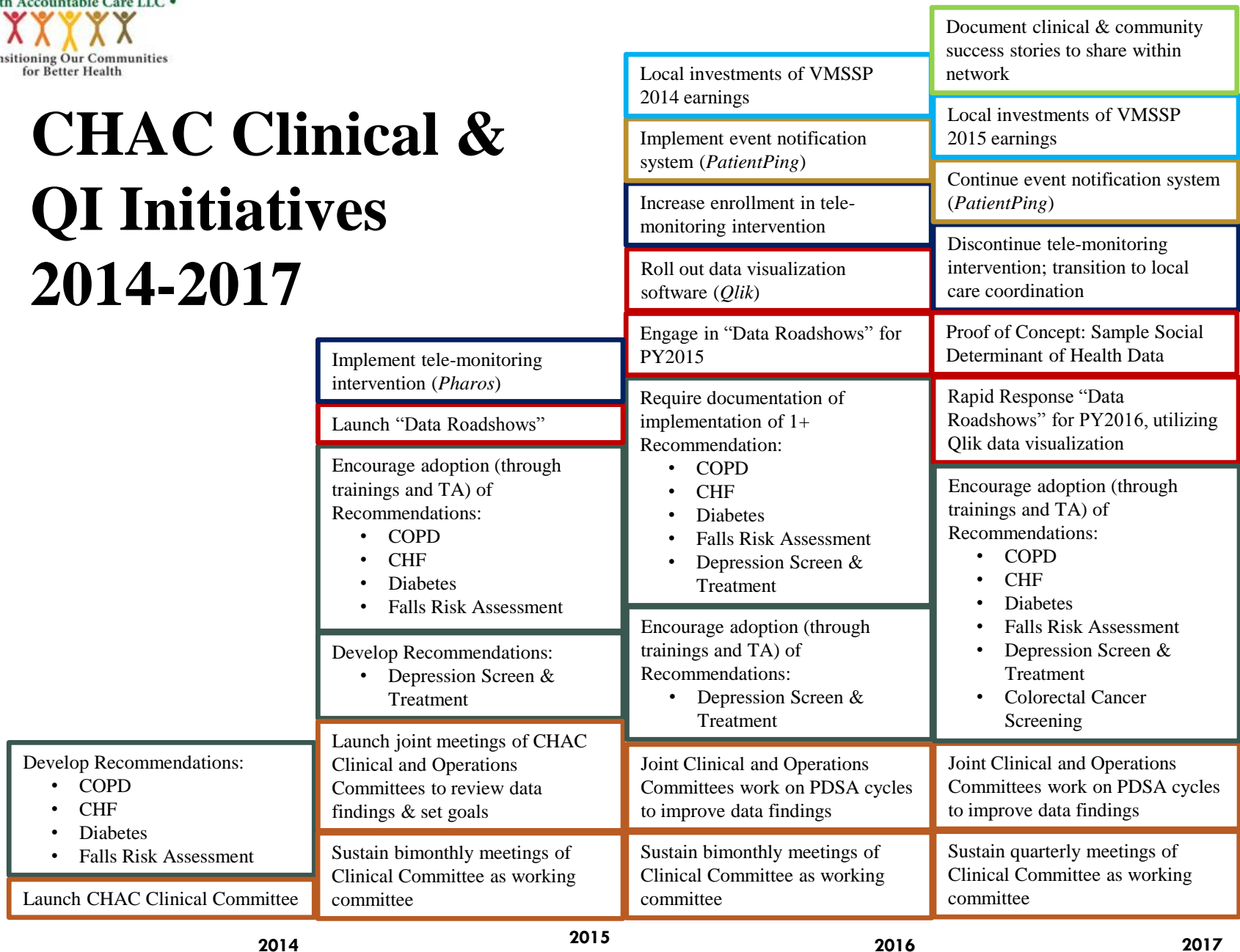
Plan documented: **73%** Plan documented: **61%**

CHAC Standards: Raising the Bar

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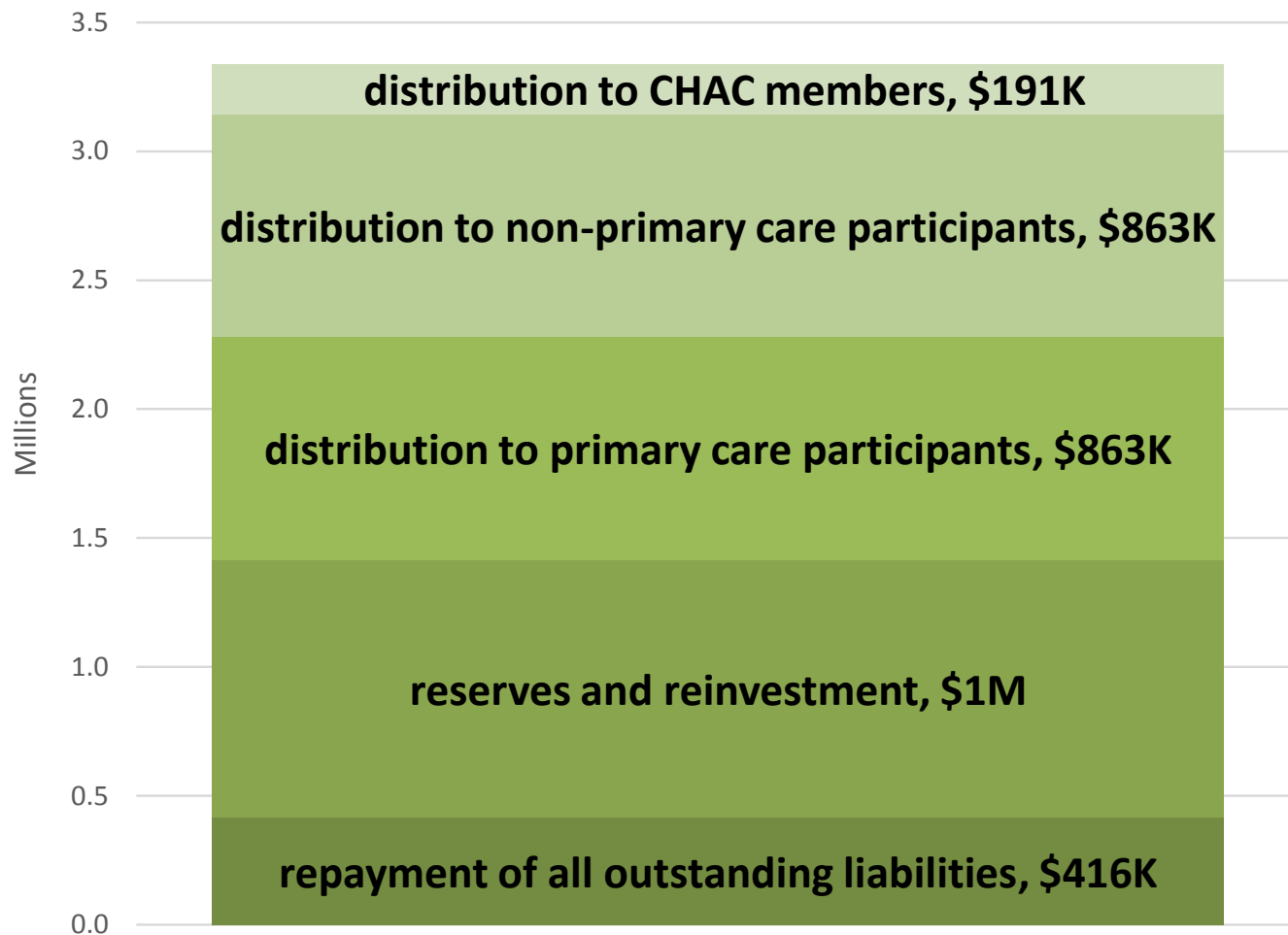
	2015	2016	
Standard	Primary Care Participants	Primary Care Participants	Non-Primary Care Participants
Maintain NCQA PCMH recognition at Level 1 or above	✓	✓	N/A for Non-PC
Cooperate with ACO Quality Reporting Requirements	✓	✓	N/A for Non-PC
Complete mandated mailings to beneficiaries	✓	N/A in 2016	N/A in 2016
Participate in Tel-Assurance remote monitoring program	✓		N/A for Non-PC
Participate in required CHAC compliance trainings	✓	✓	✓
Demonstrate documented integration of 1+ CHAC evidence-based recommendations		✓	✓
Participate in PatientPing event notification initiative or alternative.		✓	✓

CHAC Clinical & QI Initiatives 2014-2017



CHAC Received \$3.35M 2014 Medicaid Savings to Distribute

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CHAC's distribution methodology allowed for significant reinvestment at the local level in primary care and community partners!

Community Investment Examples

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□ Berlin

- Combined case review meetings for shared FQHC, mental health, and home health patients. Each organization to hold a CME training.

□ St. Albans

- Implemented home health visits for all transition patients. The visit includes medication reconciliation, establishment of follow-up with PCP and transportation, administration of the GAD-7 and PHQ-2 or 9, and assessment and coordination of additional services needed.

□ St. Johnsbury

- Community mental health center increased staff to work with ER patients with mental health issues.

□ Newport

- Leadership development conference for all non-profits in the Northeast Kingdom.

CHAC Support for APM

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Per resolution of CHAC's Members, 5/1/2017:

- CHAC remains engaged and supportive of Vermont's All Payer Model. CHAC remains committed to representing our patients and providing a comprehensive and integrated model of care.
- CHAC believes that a successfully transformed health system has the following characteristics:

CHAC's “10 Points” for a Transformed Health Care System

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- ❑ **Strong, well-supported Patient-Centered Medical Home** with resources to prevent chronic disease
- ❑ **Time to address issues** underlying chronic disease and mental health
- ❑ **Mental health/behavioral health and primary care work together**
- ❑ **Home health and primary care work together**
- ❑ **Community-based social service agencies are fully integrated** with primary care practices
- ❑ Community partners work with primary care to offer “**health coach**”
- ❑ Communities **integrate wellness initiatives with schools, employers, etc.**
- ❑ **Hospitals are stable** and positioned to meet acute inpatient/outpatient needs
- ❑ **System of care focused on local and regional levels**
- ❑ **Blueprint team retains independence and neutrality** to lead transformation effort