Population Health: Sharing A Parkland Perspective

Sue Pickens, MEd, PCMH CCE
Who is Parkland?

Dallas County Hospital District – d/b/a Parkland Health & Hospital System:

- “Safety Net” provider for 2.5 million Dallas County Residents
- Primary teaching hospital for UT Southwestern Medical School
- Major regional resource in the event of a disaster
- Patient Demographics (COPC): 54.0% Hispanic, 29.2% African American, 11.7% Caucasian, 3.7% Asian, 1.4% Other
- Payor – Medicaid, CHIP and Parkland Charity

Operating:
- 1.3 million patient visits a year
- 770 staffed adult inpatient beds and 65 staffed neonatal beds
- First Level I Trauma Center in North Texas
- A regional burn unit, second largest civilian burn unit in the nation
- One of the nation’s largest Women’s Health Service with over 10,000 deliveries a year
- A network of community-oriented primary care health centers, women’s health centers, homeless program, geriatric program, refugee outreach program
- The Dallas County Jail health system
- Operating budget of $1.3 billion
Overview

Population Health - Overview

Population Health Parkland

Pay for Performance Models
Medical Homes and Accountable Care Organizations: If We Build It, Will they Come

• The medical home is a patient-centered model which provides high quality, low cost, and convenient care.

• A transformative shift to place the patient at the center of the delivery system, rather than the clinical team.

• Parkland is a look alike umbrella of an organizational structure like an ACO consisting of individual medical homes.
Patient makes PCP appointment for cough and sore throat

Patient receives care for acute illness

Patient returns home with antibiotic prescription

Physician flagged patient has asthma, also addresses condition during acute visit

Patient Makes PCP Appointment

Physician flagged patient has asthma, also addresses condition during acute visit

Care coordinator assists coordination of specialist care

Medical home established care team continues treatment across settings enabled by IT connectivity

Care coordinator/parent navigator educates family on available resources and support in community

Source: Advisory Board Company, 2010
## PCMH Concept

### Key Facets of Patient-Centered Medical Homes

<table>
<thead>
<tr>
<th>Facet</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enhanced Access After Hours &amp; On-Line</td>
<td></td>
</tr>
<tr>
<td>Long-term Patient &amp; Provider Relationships</td>
<td></td>
</tr>
<tr>
<td>Shared Decision Making</td>
<td></td>
</tr>
<tr>
<td>Patient Engagement on Health &amp; Healthcare</td>
<td></td>
</tr>
<tr>
<td>Team-Based Care</td>
<td></td>
</tr>
<tr>
<td>Better Quality &amp; Experience of Care</td>
<td></td>
</tr>
<tr>
<td>Lower Cost from Reduced Emergency Department &amp; Hospital Use</td>
<td></td>
</tr>
</tbody>
</table>

*(NCQA, 2014)*

- Comprehensive Care
- Patient-Centered
- Coordinated Care
- Accessible Services
- Quality and Safety

PCMH Aligning Reimbursement and purchasing

Since 2006 States with medical home activity for Medicaid/CHIP (Texas does not participate in: multi-payer medical home initiative, ACA Section 2703 Health Homes, aligning medical home payment with national or state-developed qualification standards, or payments to community-based teams or networks to support primary care practices)

There are about 40,000 clinics with 9,000 primary care practices are recognized as NCQA PCMH

(NCQA, 2015)

http://www.nashp.org/medical-homes-map/
The PCMH Framework, enhances the Triple-Aim of Healthcare by ensuring that patients receive the right care at the right time at the most affordable price:

- Involving Patients and Families
- Redesign of primary care services and structures (virtual visits, visits at the Mexican Consulate)
- Patient centeredness, quality metrics, population health management, utilization management
- Improving care coordination across the System and Community (e.g., integration of specialty, inpatient and primary care as well within community organizations)
- Reducing costs by improving quality and efficiency of care, patient engagement, and care coordination
  - Improved quality metrics
    - Reduced Readmissions
    - Reduced ED visits
    - Improved preventive care
    - Pre-visits planning (improved efficiency)
    - Improved care coordination
The PCMH Structure Can Provide Financial Benefits to Providers and Payors Through New Payment Models and Improved Return on Investment (ROI) by:

- Preparing for the shift to Value-Based Reimbursement
  - Alignment with PQRS and MU
- Improving collaboration between payors and providers
  - Asthma quality metrics
  - HEDIS metrics and incentives
- Improved quality and efficiency of care

- Pay for performance (value based care)
  - 1115 Waiver
  - PQRS
  - MU, core measures, etc.
  - Shared incentives with Medicare Advantage Plans for HEDIS Measures
Parkland PCMH Model

Population Management
- Well Child
- Asthma
- Obesity (adult and pedi)
- High Risk ED/Hospital Admits (adult and pedi)
- DM
- CHF
- Patients not recently seen
- Medication Monitoring

Effective Care Processes
- Pre-visit
- Visit
- Post Visit
- Registries
- Case management
- Goal setting/Motivational Interviewing

Improved Outcomes
- ↑ Immunization Rates
- ↑ Preventive/Chronic Screenings
- ↓ ED/Hospital admits
- Timely referrals
- ↓ BMI’s
- ↓ HgA1C
- ↓ LDLs
# Certification cost

<table>
<thead>
<tr>
<th>Sites</th>
<th>Number of Clinicians/Site</th>
<th>Application Fees/Site</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Each practice site address is counted as a separate site</td>
<td>Enter number of clinicians at each site. Count any clinician who will be included as one clinician (not FTEs).</td>
<td>For Corporate Site Fee: If 3-5 sites enter $1,100 If 6 - 9 enter $2,200 If 10-15 enter $3,300 If 16-19 enter $4,400 If 20-25 enter $5,500 If 25-29 enter $5,500</td>
<td>Total of fees and tools per site</td>
</tr>
<tr>
<td>Corporate Site</td>
<td>N/A</td>
<td>Enter $275 for each clinician but not more than $3,300:</td>
<td></td>
</tr>
<tr>
<td>Site 1</td>
<td></td>
<td></td>
<td>3,300</td>
</tr>
<tr>
<td>Site 2</td>
<td>12</td>
<td></td>
<td>3,300</td>
</tr>
<tr>
<td>Site 3</td>
<td>7</td>
<td></td>
<td>1,925</td>
</tr>
<tr>
<td>Site 4</td>
<td>2</td>
<td></td>
<td>550</td>
</tr>
<tr>
<td>Site 5</td>
<td>6</td>
<td></td>
<td>1,650</td>
</tr>
<tr>
<td>Site 6</td>
<td>7</td>
<td></td>
<td>1,925</td>
</tr>
</tbody>
</table>

Organization must be approved by NCQA as eligible for the multi-site process.

**GRAND TOTAL**

(Baker & Baker, 2014; NCQA, 2014)
Funding streams such as capital budget requests are necessary to implement PCMH model:

1115 Waiver- Value Based Payment
Enhance/Expand Medical Homes- COPC

• Need Additional FTEs to support the advancement of PCMH
• Need Additional Technology to support the advancement of PCMH (report writing, telemedicine, retinal scanners)

(Baker & Baker, 2014)
<table>
<thead>
<tr>
<th>Budget FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.7 FTE Register Nurse II’s</td>
</tr>
<tr>
<td>1 FTE Intermediate Project Analyst</td>
</tr>
<tr>
<td>12 FTE Medical Practice Assistants</td>
</tr>
<tr>
<td>9.7 FTE Medical Assistants</td>
</tr>
<tr>
<td>Total- 32.4 FTEs</td>
</tr>
</tbody>
</table>

***Does not include Provider FTEs***
Adult Preventive Services

1. Mammography for Women >=40 – 69 (birthday month)
2. Pneumococcal vaccine for these >=65 (birthday month)
3. Screening for colorectal cancer – 50–75 years of age who had appropriate screening for colorectal cancer (birthday month)
4. Influenza Reminders (MyChart)

Adult Chronic Care

1. Frequent of HBA1c – age 18-75 (birthday month)
2. Telephonic Post visit follow-up (hospital) high risk – TCU (diabetes patients)
3. LDL for Diabetic patients – age 18-75 (birthday month)
Pediatric Chronic Care Services

1. Flu shot for asthma patients (asthma patient who did not receive their flu shots in the current and last flu season), send letter in August and January
2. Uncontrolled asthma- pt using rescue inhalers (birthday month)
3. Telephonic follow up with patient who went to ED or had a hospital admission for asthma

Pediatric Preventive Services

1. Reminder of 4th DTaP For 15 month old (birthday month)
2. Reminder of 30 month HM visit (birthday month)
3. Reminder of 4 year HM visit (birthday month)
4. HPV 11 to 12 year olds (monthly)
Thank You...

Gracias...
Dear Parent/Guardian,

Children with asthma should get a flu vaccine every year.
If you have been told your child has asthma, please call 214-266-4000 to schedule a flu vaccine appointment.
Bring your child and their vaccine record to the appointment.
If your child had their flu vaccine at another clinic, please call to tell us when and where the flu vaccine was done. Thank you.

Parkland, your medical home, dedicated to your health and well-being.

Querido padre/tutor

Los niños con asma deben ser vacunados cada año contra la influenza (gripe).
Si a usted le han dicho que su hijo/a sufre de asma. Por favor llame al 214-266-4000 para programar una cita para ser vacunado contra la influenza.
Por favor traiga a su niño y la cartilla de vacunación de su hijo/a a la cita.
Si es que a su niño ya le vacunaron contra la influenza en alguna otra clínica, Por favor llámenos y diános cuando y en donde lo vacunaron. Gracias.

Parkland su hogar médico, dedicado a su salud y bienestar.
## Cost of Financing - Reminders

<table>
<thead>
<tr>
<th>Preventive/Chronic Care Reminder</th>
<th>Estimated monthly impact per historical data</th>
<th>Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pneumovax Vaccine</td>
<td>40 per month</td>
<td>$100</td>
</tr>
<tr>
<td>HbA1C Test</td>
<td>101 per month</td>
<td>$751</td>
</tr>
<tr>
<td>LDL Test</td>
<td>193 per month</td>
<td>$120</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>703 per month</td>
<td>$5230</td>
</tr>
<tr>
<td>Breast Cancer Screening</td>
<td>(Mammography is mailing 10,000 letters a year for the System)</td>
<td>Budget in another cost center</td>
</tr>
<tr>
<td>Pedi Flu vaccine Asthma</td>
<td>3,000 per season</td>
<td>$1860</td>
</tr>
<tr>
<td>Pedi Uncontrolled Asthma</td>
<td>250 per month</td>
<td>$1860</td>
</tr>
<tr>
<td>4th DTaP</td>
<td>476 per month</td>
<td>$3541</td>
</tr>
<tr>
<td>30 month HM</td>
<td>200 per month</td>
<td>$1488</td>
</tr>
<tr>
<td>4 year HM</td>
<td>150 per month</td>
<td>$1116</td>
</tr>
</tbody>
</table>

(Baker & Baker, 2014)
Current Registries –
Patient Centered Medical Home, Diabetes, CHF, CKD, Obesity, Asthma

- Identify populations of patients with common chronic disease
- Facilitate clinical care management based on ‘Best Practice’ and Clinical Guidelines
- Demonstrate effectiveness of clinical care and pre visit care planning
- Coordinate care and meaningful use of resources
- Associated with multiple 1115 Waiver projects for hospital funding
- Improves patient outcomes by quickly identifying patient needs and corresponding clinical team actions
Examples of Impacts of PCMH

Best Practice-Preventive Health Procedures Completed on DM Registry Patient

- **Retinal Eye Exams**
  - Oct-14: 30.47%
  - Nov-14: 30.91%
  - Dec-14: 31.54%
  - Jan-15: 31.95%
  - Feb-15: 32.99%
  - Mar-15: 34.89%
  - Apr-15: 36.04%
  - May-15: 38.48%
  - Jun-15: 40.44%

- **Diabetic Foot Exams**
  - Oct-14: 16.2%
  - Nov-14: 16.9%
  - Dec-14: 17.5%
  - Jan-15: 16.9%
  - Feb-15: 16.9%
  - Mar-15: 22.1%
  - Apr-15: 31.3%
  - May-15: 38.4%
  - Jun-15: 43.0%

- **HBA1C>9**
  - Oct-14: 33.5%
  - Nov-14: 29.9%
  - Dec-14: 27.7%
  - Jan-15: 29.6%
  - Feb-15: 29.9%
  - Mar-15: 30.5%
  - Apr-15: 29.4%
  - May-15: 28.9%
  - Jun-15: 28.2%
Examples of Impacts of PCMH

Seamless Care Coordination
- Care Everywhere
- MyChart

Percent Handled MyChart Patient Messages Within Specified Business Days

Reporting Period: 05/02/2016 - 06/01/2016

5 Average Business Days Turnaround
56% Percent Handled Within 3 Business Days

Percent Handled Within 3 Business Days By Department
Pediatric Asthma care coordination from ED/inpt facility:

Implementation of pediatric population health nurse
Care coordination for pediatric asthma patients discharged from the emergency department (ED) or from an Inpatient Admission.

Results

Baseline data- 32% of patients following up with their Primary care provider without the population health nurse to

70% of pediatric patients discharged following up with their primary care provider after ED or inpatient discharge.

(Parkland Health & Hospital System, 2011)
• Increased access for patients in primary care clinics

• Intervention - weekly shared medical appointments

• Re-designed the refill process with pharmacy and providers

• Reduced visits to the ED and main campus urgent care ED visits by 22% in a three month time period

(Parkland Health & Hospital System, 2011)
## Impact of Preventive Screenings

<table>
<thead>
<tr>
<th>Screenings</th>
<th>Non-Medical Home Pts- not screened</th>
<th>Medical Home Pts- not screened</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Cancer Screening</td>
<td>57%</td>
<td>29%</td>
<td>28%</td>
</tr>
<tr>
<td>Colorectal Cancer</td>
<td>52%</td>
<td>46%</td>
<td>7%</td>
</tr>
<tr>
<td>Pediatric Asthma up to date action plan</td>
<td>66%</td>
<td>53%</td>
<td>13%</td>
</tr>
</tbody>
</table>

(Parkland Health & Hospital System, 2015)
PCMH patients fairs better when ED utilization is concerned

<table>
<thead>
<tr>
<th>Week</th>
<th>Medical Home No</th>
<th>Medical Home Yes</th>
<th>Difference Percent difference from PCMH patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>28-Jun</td>
<td>69.8%</td>
<td>30.2%</td>
<td>39.6%</td>
</tr>
<tr>
<td>9-Jul</td>
<td>55.7%</td>
<td>44.3%</td>
<td>11.5%</td>
</tr>
<tr>
<td>12-Jul</td>
<td>58.5%</td>
<td>41.5%</td>
<td>17.0%</td>
</tr>
</tbody>
</table>

(Parkland Health & Hospital System, 2015)
Overview

Population Health

Population Health Parkland

Pay for Performance Models
Parkland Participates in:

- Meaningful Use Stage 2
- PQRS Group Practice
  (12 measures for 2016)
- Value Based (Payment) Modifier
- Core Measures – Still Abstract Charts
- Inpatient Quality Reporting (IQR) (eligible for full market basket 2014)
  (Still Abstract Charts)
- eCQMs (MU, PQRS, IQR)
- HEDIS measures
  (through payer participation)
- Leap Frog (Hospital Safety Report)
  (B in 2015)
- 1115 Waiver
<table>
<thead>
<tr>
<th>PQRS measure number</th>
<th>Measure Name and NQF Number</th>
<th>Performance rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>CAD/Beta Blocker Therapy</td>
<td>82.39</td>
</tr>
<tr>
<td>50</td>
<td>Urinary Incontinence</td>
<td>99.25</td>
</tr>
<tr>
<td>110</td>
<td>Influenza Immunization</td>
<td>86.42</td>
</tr>
<tr>
<td>111</td>
<td>Pneumonia Vaccination status for Older Adults</td>
<td>89.89</td>
</tr>
<tr>
<td>112</td>
<td>Breast Cancer Screening</td>
<td>81.42</td>
</tr>
<tr>
<td>113</td>
<td>Colorectal Cancer Screening</td>
<td>75.28</td>
</tr>
<tr>
<td>118</td>
<td>CAD ACE ARB</td>
<td>89.57</td>
</tr>
<tr>
<td>128</td>
<td>BMI and follow-up</td>
<td>97.79</td>
</tr>
<tr>
<td>204</td>
<td>IVD Use of Aspiring or other therapy</td>
<td>74.92</td>
</tr>
<tr>
<td>226</td>
<td>Tobacco Use Screening and intervention</td>
<td>96.99</td>
</tr>
<tr>
<td>241</td>
<td>LDL control &lt;100</td>
<td>56.93</td>
</tr>
</tbody>
</table>
“A small group of thoughtful people could change the world. Indeed, it’s the only thing that ever has.”

Margaret Mead

Thank you!

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