TCPI Exemplary Practice Performance Summary, January 2019
St. Elizabeth's Health Center
Dr. Mark Schildt, Chief Medical Officer
FQHC with exceptional performance in clinical outcomes and inpatient/ED utilization

St. Elizabeth's Health Center (SEHC) is a faith-based Federally Qualified Health Center (FQHC) located in Tucson, Arizona, providing primary medical, dental care, behavioral health, nutrition, services to Medicare, Medicaid and uninsured patients. We serve a population of approximately 8,000 members with 11 primary care providers and 8 specialty providers in 1 location. Our goal to achieve NCQA Patient-Centered Medical Home recognition, which we accomplished in December 2017, intensified our focus to provide the best care possible for our fragile and underserved population.

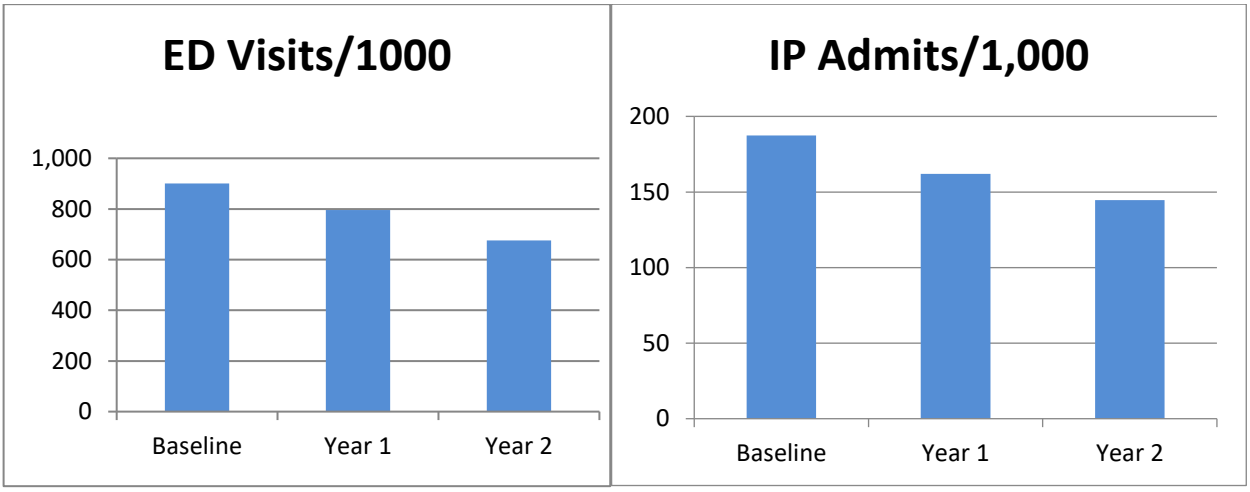
Category	Indicator	Goal	2013	2014	2015	2016	2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Quarterly Change	Threshold	Target	Stretch Goal
Clinical	Cervical cancer screening	Increase percentage of female patients aged 24-64 who received a cervical cancer screening in the past 3 years	50%	50%	31%	51%	62%	70%	70%	70%	67%	↓	54%	65%	70%
Clinical	Colorectal cancer screening	Increase the number of patients aged 50-75 who received a colorectal cancer screening	12%	16%	32%	43%	62%	70%	68%	68%	66%	↓	40%	65%	70%
Clinical	Coronary Artery Disease (CAD) Lipid Therapy	Increase percentage of patients age 18 or older with a diagnosis of CAD who were prescribed a lipid lowering therapy	61%	78%	81%	86%	85%	86%	86%	81%	84%	↑	80%	89%	96%
Clinical	Ischemic Vascular Disease (IVD): Aspirin or Anti-thrombotic Therapy	Increase the percentage of patients aged 18+ with a diagnosis of IVD or AMI, CABG, or PTCA procedure with aspirin or other anti-thrombotic therapy	63%	69%	78%	87%	86%	86%	87%	88%	83%	↓	78%	91%	98%
Clinical	High Blood Pressure Control	Increase the percentage of hypertensive patients aged 18-85 whose most recent blood pressure was less than 140/90.	57%	58%	58%	58%	56%	58%	55%	57%	53%	↓	62%	67%	72%
Clinical	Diabetes Control	Increase the percentage of diabetic patients aged 18-75 whose most recent HbA1c reading was ≤ 9	24%	23%	39%	50%	60%	33%	48%	61%	63%	↑	68%	73%	79%
Clinical	Asthma Pharmacologic Therapy	Increase percentage of patients age 5-40 w/ persistent asthma who were prescribed appropriate medication during the measurement year	No data	No data	80%	90%	80%	80%	84%	80%	85%	↑	87%	94%	100%
Clinical	Childhood Immunization	Increase percentage of children who have received age appropriate vaccines prior to their 2nd birthday	No data	No data	55%	16%	21%	13%	9%	7%	6%	↓	43%	46%	50%
Clinical	Weight Assessment and Counseling for Pediatrics	Increase percentage of patients age 3-17 with a BMI percentile and counseling on nutrition and physical activity documented for the current year	0%	0%	8%	18%	43%	23%	37%	42%	58%	↑	63%	68%	73%
Clinical	Adult Weight Screening and Follow-up	Increase the percentage of patients 18+ with BMI charted and follow-up plan documented if overweight or underweight	21%	23%	34%	73%	83%	83%	81%	84%	82%	↓	63%	87%	94%
Clinical	Tobacco Use Screening and Cessation	Increase percentage of patients age 18+ who were screened for tobacco use and received cessation counseling intervention or medication if identified as a tobacco user in the prior year	64%	78%	86%	98%	96%	96%	96%	95%	95%	No Change	85%	98%	100%
Behavioral Health	Access to Care	Improve the time interval between an internal Behavioral Health referral and the patient's Behavioral Health intake appointment	No Data	No Data	No Data	No Data	No Data	5	5	9			10 Days	7 Ddays	5 Days
Behavioral Health	Depression Screening	Increase the percentage of patients age 12+ who were screened for depression and had a follow up plan documented if considered depressed	0%	0%	1%	83%	81%	70%	76%	80%	79%	↓	60%	85%	92%

Our practice exemplary performance was achieved by focusing, initially, on meeting and exceeding the Health Center's Uniform Data System (UDS) national measures. Utilizing our electronic health record, we generated population health reports to identify care gaps within our population. In conjunction with feedback from clinical team, work group designations, PDSA cycles, and weekly/monthly meetings, our practice successfully met or exceeded the national UDS targets for several of the measures. As chart above illustrates, in 2015, cervical cancer screening was at 31%, which was below threshold of the 2016 UDS national average. In 2018, for 3 consecutive quarters, we met or exceeded the stretch goal by achieving 70%, meaning 8% above the UDS target. Colorectal cancer screening measure, in 2015, we met or exceeded threshold at 32%. In 2018, we maintained an average of 68%, which is 8% above the threshold. Additionally, Coronary Artery Disease, Diabetes Control, and Asthma Pharmacologic Therapy are 3 measures showing continuous improvement and are currently *Meeting/Exceeding UDS Thresholds or Meeting/Exceeding UDS Targets*.

Furthermore, we reduced emergency department (ED) and inpatient visits (IP) by improving care coordination processes for closing the referral loop and outreach processes for inpatient discharges. We reduced ED visits for three consecutive periods, the most recent showing a 31.5% decrease compared to baseline. Additionally, we achieved reductions in IP admissions for the same three consecutive periods, the latest showing a 29.0% decrease compared to baseline (*see Table 1 and Figure 1 below*). Estimated cost savings from ED visit reduction totaled $965,000 (using an average cost per ED visit of $449). Similarly, using an average cost per IP admission of $5,761, the estimated savings from reduced IP admissions totaled $2.5 million.

Table 1/Figure 1 – Reduction in ED Visits/IP Admits

Measure Name	Year 1 Change	Year 2 Change	Most Recent 12 Month Change
ED Visits	-11.7%	-25.1%	-31.5%
IP Admits	-13.6%	-22.9%	-29.0%

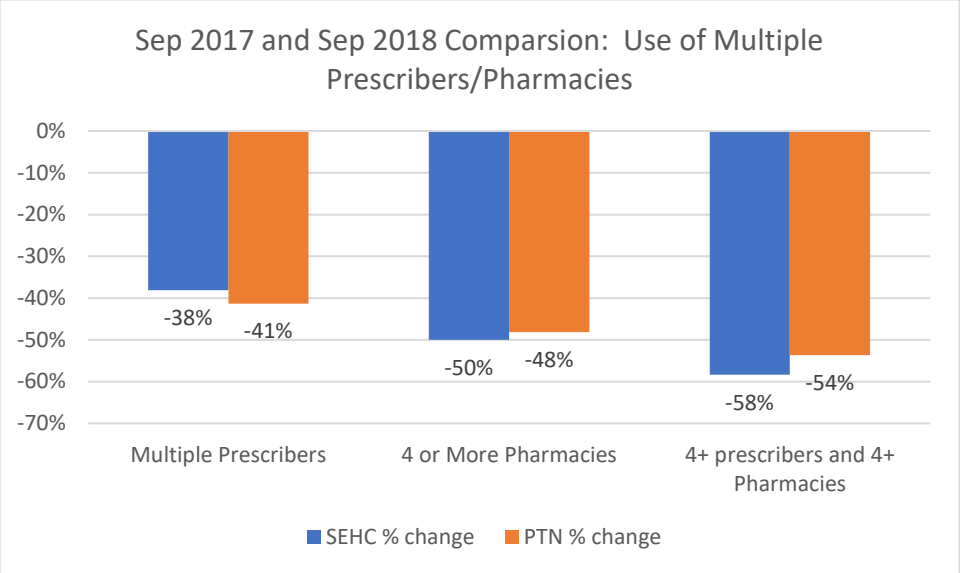


Staying true to our vision of person and family-centered care design, we expanded our focus to another population to address the emerging opioid national crisis. According to the Arizona Department of Health Services, between June 2017 and May 2018, Pima County had 1,359 reported cases of opioid overdoses, with 15% being fatal. With state and national emergency called on opioid utilization, our executive leadership, pledged to prevent and combat use disorders, opioid overdoses, and related deaths

Applying our regular improvement methodologies, our initial step was to obtain feedback from the rest of the practicing providers which meant holding multiple, consecutive meetings to gain consensus/buy-in, not only, on such undertaking, but also, to inquire as to the process, expectations, deliverables. Using the Arizona's Opioid Prescribing Guidelines as our tool, we began the transformation processes which included:

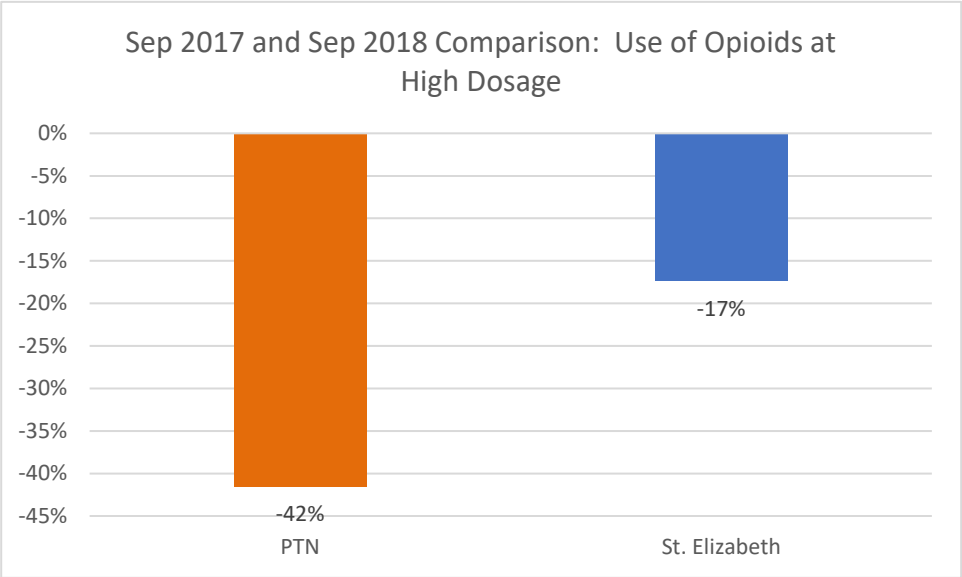
- Revise policy and procedures for opioid treatment to correspond with CDC and Arizona Opioid Prescribing Guidelines
- Update/develop forms such as opioid treatment agreement, informed consent, pain assessment and documentation tool (PADT), and opioid risk tool (ORT)
- EHR modifications: create opioid document, assigned scanned documents to auto-populate flowsheet, create custom flowsheet view, add naloxone to EHR custom med list, create quick texts for provider documentation
- Collect and maintain substance use treatment resources, relevant to the patient population served (use of internal behavioral health and collaboration with external providers)
- Create a registry for established patients on long-term opioids and apply risk mitigation strategies (EHR based)

Figure 2 – Use of Multiple Prescriber Comparison



The graph reflects a comparison between Sep 2017 performance and Sep 2018 performance. In two of the 3 HEDIS measure elements, our practice performed slightly better than the PTN performance. Similarly, between June 2017 and May 2018, Arizona saw a 17% decrease in opioid overdose cases.

Figure 3 – Use at High Opioid Dosage Comparison



We continue to work with providers and patients in reducing the number of patients who are taking high dosage of opioids. Figure 3 reflects our continuous improvement initiative as our PTN had a greater reduction than our organization. Given the size of our population, a 17% decrease is a step in the right direction.

Consideration for patient needs and desired health outcomes, along with provider buy-in, we designed a treatment plan to mitigate the patients' risks while on the medication, which included a tapering plan and alternative treatment options. Through this process, we identified patients whose complexity was significantly greater due to their other physical health or behavioral health diagnoses. For these patients we continually assessed the need to transition patients to a behavioral health provider and/or a medication assisted treatment (MAT) provider when appropriate.

Our practice continues to develop and enhance quality improvement efforts with the inclusion and feedback from patients. Patient engagement is key to the continued success of our practice and services. As such, we collect patient experience surveys on an annual basis. The survey includes categories such as access, communication, and self-management and care coordination. Key indicators:

Survey Question	Performance
Recommend SEHC	97%
Provider Listens	95%
Care Coordination	93%
Education about Improving Health	95%

Finally, we have success in managing relations with value-based contracts, most recently joining Equality Health who will provide additional assistance in managing value-based relationships. We are confident that practice transformation, leading to improvement in health outcomes and cost savings, is an achievable aim.

St. Elizabeth's Health Center is an active participant of the Practice Innovation Institute (Pii), Arizona's Practice Transformation Network.

As of September 2018, SEHC reached Phase 3 of the 5 Phases of Transformation.

Practice Innovation Institute
Engage. Transform. Reward.