TCPI Exemplary Practice Performance Summary, August 2019
Maricopa Integrated Health System
Lene Hudson – Director of Case Management
Physician led clinical initiatives aligned with organization's leadership mission, vision, and goals. Use of data to drive performance outcomes.

Our organization is composed of a 325 medical bed hospital, a 289 behavioral health bed medical center, two behavioral health facilities, an outpatient specialty center and thirteen family health centers that are Federally Qualified Health Center Look Alike status. Maricopa Integrated Health System (MIHS) is public teaching hospital and safety net system in Phoenix Arizona. We have been serving the community for more than 140 years and have been providing care to over 16,500 inpatients and over 432,600 outpatients annually. We employ over 3,500 health care professionals and have partnership with 770 physicians and other advanced health care providers. We are an urban health care system serving all of Maricopa County. Close to 60% of our population are Medicaid recipients and 20% Medicare. The remaining 20% are uninsured or underinsured.

We are extremely proud of our overall accomplishments, particularly the re-verification as an adult and pediatric burn center by the American Burn Association and the American College of Surgeons, making us the only verified burn center in the state of Arizona and one of 58 verified burn centers nationally. Additionally, all our family health centers received the highest level of recognition from the National Committee for Quality Assurance's Patient-Centered Medical Home program.

Given our large member population, it was imperative that we addressed the needs of the population as a whole. In line with TCPI overarching project goals and our organizations, both, regulatory and contractual requirements, we committed to building practice transformation on evidence-based solutions and improving health outcomes, ultimately reducing overall healthcare costs. Through such approaches we made significant progress toward system wide performance improvements.

The table below illustrates our continued commitment to quality improvement since 2015. Our FQHC Look-Alikes are part of the overall Healthy Communities Collaborative Network (HCCN). We outperformed other peer organizations in three of the UDS measures: Colorectal Cancer Screening, Dental Sealants, and Diabetes A1C. The improved clinical outcomes within these 3 measures reflect our organization's goals. The strategy to address the diabetic population, described below, is the process we continue to follow in our continued pursuit for improving the health and clinical outcomes of our population.

			UDS 2015	UDS 2016	UDS 2017	UDS 2018*	HCCN - UDS 2018*		
UDS - HP2020 Measures	HP2020 Goal	AHCCCS Goal	MIHS: FQHC-LA	MIHS: FQHC-LA	MIHS: FQHC-LA	MIHS: FQHC-LA	*HCCN Average*	# who Met/Exceeded HP 2020 Goal	Highest Performers
Measure 1: Prenatal Care Entry (1st Trimester)	***77.9%***	-	54.61%	59.25%	61.52%	61.52% ↑	**66.22%**	**5**	100%**
Measure 2: Childhood Immunizations (2 years old)	***80.0%***	-	87.14%	35.71%	33.75%	29.72% ↓	**32.32%**	0	66.67%**
Measure 3: Cervical Cancer Screening	***93.0%***	-	60%	50%	42.45%	48.24%	**51.14%**	0	89.51%
Measure 4: Colorectal Cancer Screening	***70.5%***	**> 65%**	32.86%	51.43%	40.52%	48.39%	**39.14%**	0	61.75%
Measure 5: Dental Sealants	***28.1%***	-	56.33%	73.13%	78.89%	**79.17%** ↑	**60.98%**	**14**	92.94%
Measure 6: Low Birth Weight *(<2500 grams)*	***<7.8%***	-	7.92%	8.57%	6.97%	**7.74%**	**6.78%**	**16**	0%**
Measure 7: Hypertension (BP < 140/90)	***61.2%***	-	52.25%	55%	58.21%	52.40%	**61.47%**	**9**	87.21%**
Measure 8: Diabetes (Hba1c >9% or no test)	***<16.1%***	**< 41%**	42.15%	44.69%	36.73%	35% ↓	**34.82%**	0	29.66%
Measure 9: Childhood & Adolescent Weight Assessment/Counseling	***55%***	**> 55%**	82.86%	71.43%	57.32%	60.04% ↓	**70.74%**	n/a	95.52%

*UDS 2018 Preliminary Report
**Small patient population

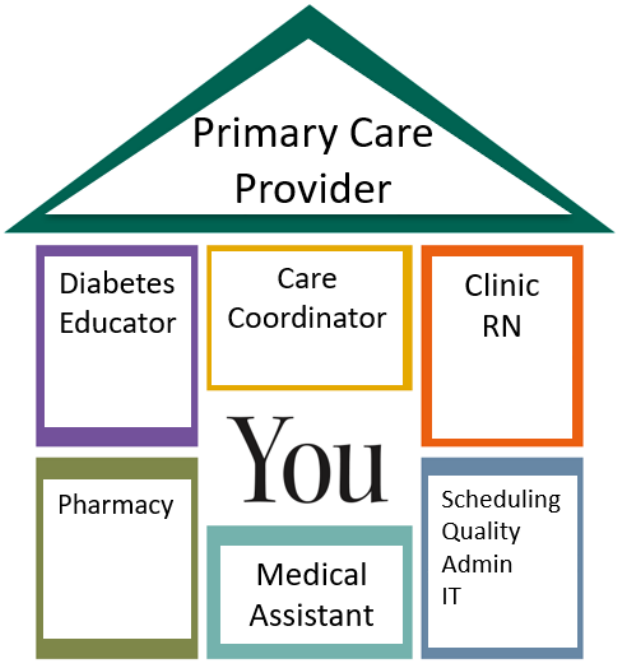
Identification of the Problem and Plan for Improvement

Our population health priority focused on managing the high-risk diabetic patient given that 35% of our diabetic patients had poor glycemic control (HbA1C>9) and, furthermore, the implications of developing comorbid conditions. For every 1% reduction in HbA1c, there is a 40% reduction in risk for developing retinal, renal, and neuropathic diseases. Additionally, there is a 40% reduction in risk for developing myocardial infarction. We acknowledged that in order to optimize outcomes, diabetes care needed to be individualized for each patient, taking in consideration the multiple social determinants of health factors affecting our patient population.

Many of our patients have social determinant of health (SDOH) barriers such as access to care, homelessness, and food insecurities. In addition to SDOH, we also have a large population with behavioral health conditions. Many of our patients were not completing their labs or returning for follow up visits. When patients did present to care there were often other pressing issues to address and we missed opportunities to close care gaps. Thus, our efforts to improve population health required a combination of system-level and patient-level approaches.

Once we identified the problem, we researched best practice and assembled a task team that developed a provider-led, patient-centered multi-disciplinary protocol.

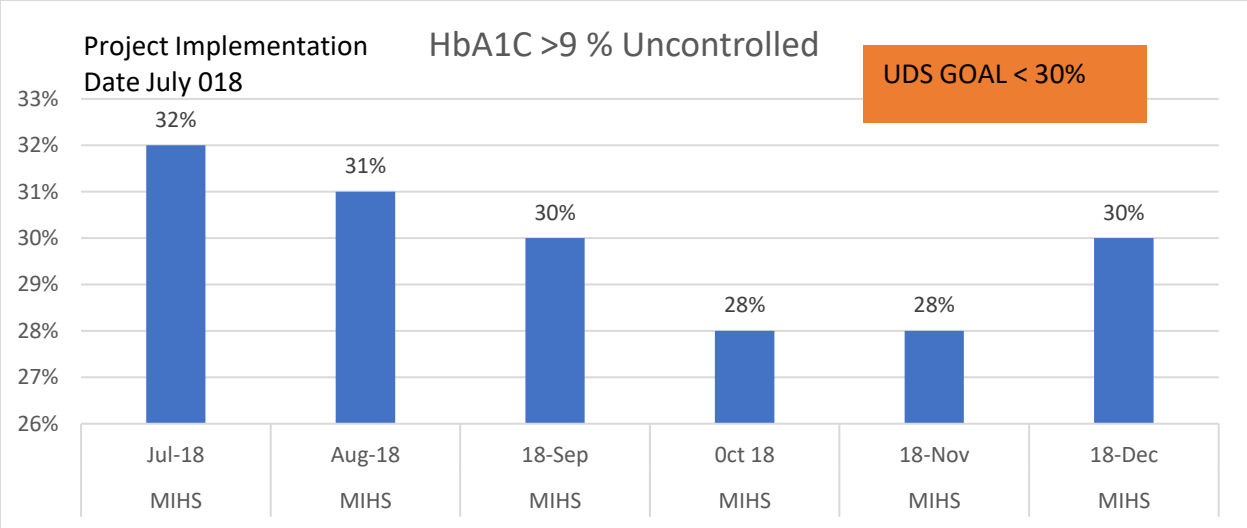
- IT developed a bulk ordering system in EPIC that applied
- rule-based logic to generate orders:
  - A1c's based on clinical guidelines (every 3 or 6 months)
  - Microalbumin if > 1 year since last test
  - Lipid Panel if > 1 year since last lab test
  - Retinal Eye Exam if > 1 year
- Care Coordinators run a monthly report to identify diabetic patients with care gaps
- The orders route to PCP for review and authentication
- Bulk communication is sent to patients to notify them of gaps and request they contact office to schedule appointment to address care gaps.
- Monthly reports identify those patients who have not responded to outreach or scheduled gap closure appointment.
- Additionally, report is generated to identify patients who requested contact via the patient portal (MyChart) but have not read their MyChart message; the team will then conduct follow-up contact via phone or mail.
- Additional support for the initiative is provided by pharmacy, diabetes educator, clinic RN, MA, schedulers, administration and quality.



Quality Metric results

In July of 2018, through the Plan, Do, Check, Act process improvement methodology and Situation, Background, Assessment, Recommendation (SBAR) technique, we rolled out our patient-centered diabetes outreach initiative.

By November 2108, we saw an 8% improvement; we were able to reduce uncontrolled A1C's from 35% in Jan to 28% in Nov. See graph below.



Even more surprising was the unexpected increase in patient adherence.

For Active Patients on DM registry with A1c (9 and above) who had an A1c ordered during the audit quarter:

Audit Timeframe	Num/Den	% Test Completed
2nd Qtr (Jul – Sep 2018)	490/1240	39.5%
3rd Qtr (Oct – Dec 2018)	1024/1380	74.2%
1st Qtr. (Jan-Mar, 2019)	766/1032	74.4%
2nd Qtr. (Apr– June, 2019)	1111/1499	74.0%

We believe this increased adherence is due to our frequent outreaches to the patient to remind them of the importance of following up on gaps in their care as well as discussing outstanding health maintenance items with staff at daily huddles.

Currently we are piloting an Integrated Behavioral Health program in three of our family health centers for patients with two or more chronic health lacking ability to manage their self-care due to life stressors such as anxiety and depression.

The patients are connected to a behavioral health counselor for solution-focused interventions and support such as functional analysis, cognitive behavioral therapy, motivational interviewing and teaching coping mechanisms for emotional wellness. This approach focuses on the whole person, as behavioral health is a major component for both self-management and medical supervision of the chronically ill patient. We are ultimately planning future integration in all our ambulatory care clinics.

District Medical Group maintains a trusted relationship with Maricopa Integrated Health System and Family Health Centers, providing all physicians and mid-level staffing. DMG Comprehensive Health Center is an active participant of the Practice Innovation Institute (Pii), Arizona's Practice Transformation Network.

Practice Innovation Institute
Engage. Transform. Reward.

As of November 2018, DMG Comprehensive Health Center completed the 5 Phases of Transformation.