TCPI Exemplary Practice Performance Summary, October 2018
NATIVE HEALTH
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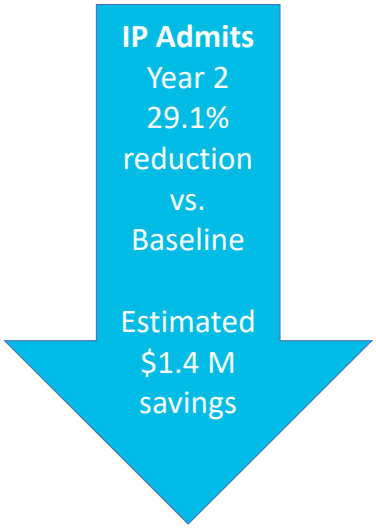
Exceptional FQHC improving the quality outcomes of an underserved population

NATIVE HEALTH is a federally qualified health center (FQHC) located in Phoenix, Arizona that strives to provide the best health care available to urban American Indians, Alaska natives, and other individuals who generally experience barriers to holistic, patient-centered, culturally sensitive health and wellness services. NATIVE HEALTH currently provides a wide range of programs including primary medical, dental, behavioral health, WIC, and community health and wellness programs. Our demographics include approximately 50% Medicaid patients and over 25% uninsured. Our population consists of those often affected by social determinants of health and poverty. We serve everyone, including special populations like urban Indian groups, refugees, migrant workers and the homeless. The practice has 3 sites providing medical, behavioral health and psychiatry services. Two of the sites also provide dental care and one provides perinatal care. We have an additional site providing primary care only. We have approximately 10 medical providers, 3 dental providers, 10 behavioral health providers, 1 psychiatry provider, and part time perinatal providers.

In 2017, our unique patient census for 2017 was between 9-10K patients. A specific difficulty in our population was the management of late stage or progressive pathology, coupled with language barriers and limited access to care, food, and medication. **Our goal was to improve the health of all individuals regardless of age, gender, race or sexual orientation or identity**. Our mission was to address the social issues that obfuscate improvement of our patients' mental and physical health. Our bold AIMS /performance that makes us a high value practice to payers and patients are **AIM 3 Reduce Unnecessary Hospital Use and AIM 4 Reduce Costs.** While we wanted to and did address all quality measures focused on by our payers, as shared, the most robust improvement is visible is the reduction of emergency department (ED) utilization and hospitalization. This practice was able to demonstrate a:



- 9.4% reduction in ED visits in Year 1 and
- 27.1% reduction in Year 2 compared to baseline. This resulted in an estimated reduction of 360 visits with a cost saving$148,138 in Year 1 and 997 visits and
- $409,941 cost savings in Year 2.

Inpatient admissions,

- Demonstrated a 3.9% reduction in Year 1
- A 29.1% reduction in Year 2 compared to baseline.
- An estimated 36 avoided admissions and $177,356 cost savings in Year 1
- There were 257 admits and $1,265,232 savings in Year 2,

This data was compiled based on attributed analysis of Mercy Care claims data.

To achieve our goals, we used electronic health record (EHR) data, claims data and health information exchange (HIE) data to identify the high-risk population(s) and patients recently discharged from nearby hospitals. We

developed a care management program as a responsibility of Clinical Case Managers, so we could continue to identify high risk patient's areas of risk. Clinical case managers were supported by a team of individuals at numerous levels of training to overcome staffing limitations, ensure everyone is working at the top of their license and allow outreaching staff to better engage patients. Unfortunately, one challenge we faced was that many patients in our population are transient and phone numbers change frequently so we still missed many patients.

- WIC called newborn parents
- Diabetes educators called diabetics
- Case managers called patients who missed referral appointments
- Nurses called patients that haven't had mammograms or colonoscopies
- Medical Assistants called patients who have missed labs
- Front desk staff called for appointment reminders and missed appointment rescheduling

A key barrier we identified to improving care was access to mental health providers. One particular example was a patient with diabetes who was uncontrolled who revealed she didn't take her medications because "she would be better off dead". **This supported the mission to provide mental health in tandem with physical health services.** As such we enhanced utilization of integrated behavioral health specialists embedded in the medical clinic to provide immediate assessments, intervention, and coordination of care with psychiatry and psychology.

We built on this to **implement interdisciplinary huddles** with mandatory attendance with medical providers and support staff, psychology, psychiatry, integrated behavioral health, dental, and community health and wellness programs. Huddles were used to take a proactive approach to identify high risk patients before the day started so we could coordinate care for patients to be seen by all necessary teams when they present for their appointment. We developed a Certified Diabetic Educator and dietitian program for enhanced patient education on nutrition, as well as glucometer and insulin education. This created better engagement for patients and reduced clinician visit burden.

Our improvement strategies reduced our unfilled appointment rate from approximately 50% to 30%, and improved productivity from 55-60% to 70-90%. These data further demonstrate that this approach to enhanced quality is financially viable in both the short and long term. Throughout the year the Medical Director focused on provider education by writing and giving lectures on up-to-date standards of care for high cost disease states. These lectures were given to staff at all levels of training to improve provider care delivery and support staff outreach. Lecture topics included, but were not limited to: DM2, HTN, HLD, CKD, MI, post stroke, HIV/STI, vaccinations, Breast CA screening, and Colon CA screening.

Another tactic used at NATIVE HEALTH was to **encourage uncontrolled and high-risk patients to have rapid follow up to capitalize on successes of short-term motivation,** so the successes could be maintained. All of our staff participated in the patient follow-up, including the case manager, diabetes educator, community health workers, and clinical staff. Patient successes and setbacks were shared daily at huddles. This rapid follow up also

allowed patients to digest information and have clarifications upon follow up, giving the patients the opportunity to validate the accurate and debunk the misinformation that is often found on the internet. Placing a limit on medication refills without follow up also provided an opportunity to identify patients whose disease control was degrading between refills.

Additionally, our patients have numerous financial limitations and barriers that affect access to care and medication. Our Medical Director approached partners in industry to provide educational material for staff, get copay assistance cards, as well as other patient assistance tools. Additionally, discounted rates were negotiated with imaging and lab facilities to reduce the cost of imaging and labs affecting cash pay patients and patients with high deductible plans. To further enhance care, we began the process to start a 340b pharmacy program for discounts for our uninsured.

In summary, to improve patient care and outcomes NATIVE HEALTH implemented interdisciplinary huddles, care coordination, utilization of health IT, open access and same day scheduling, provider engagement and empowerment, and additional programs for patient education which together **yielded a meaningful improvement in patients' lives and healthcare costs**. Each item is the embodiment of countless hours of work. These improvements are due to the staff working together to provide the best quality of care to the patients served.

Native Health is an active participants of the Practice Innovation Institute (Pii), Arizona's Practice Transformation Network.

As of September 2018, Native Health has completed the 5 Phases of Transformation.

Practice Innovation Institute
Engage. Transform. Reward.