Crescent City Beacon Community

*National Network of Public Health Institutes*
*Annual Meeting 2014, New Orleans*

# Crescent City Beacon Community: Building Shared Infrastructure for an Accountable Care Community

Anjum Khurshid, PhD, MD, MPAff
Louisiana Public Health Institute
May 2014

Crescent City Beacon Community

# Outline

- Accountable Care Community
- Crescent City Beacon Community
- Evaluating a Systems Change Program
- Shared infrastructure for CCBC and ACC
- Results from CCBC
- Lessons Learnt  - Challenges

Crescent City
Beacon Community

# ACCOUNTABLE CARE COMMUNITIES

Crescent City Beacon Community

# Accountable Care Community (ACC)

A **collaborative**, **integrated**, and **measurable** strategy that emphasizes **shared responsibility** for the **health of the community**, including health promotion and disease prevention, access to quality services, and healthcare delivery

*Healthier by Design: Creating Accountable Care Communities, 2012*

Crescent City Beacon Community

# ACC Model Components

- Integrated medical and public health models
- Utilization of interprofessional teams
- Collaboration among health systems and public health
- A robust health information technology infrastructure
- An integrated and fully mineable surveillance and data warehouse functionality
- A dissemination infrastructure
- A robust ACC implementation platform
- Policy analysis and advocacy to facilitate ACC success and sustainability

Crescent City Beacon Community

# ACC Results in Akron,OH

Already seeing positive results in 18 months

**10%**
decrease cost per month of care for diabetics

**>50%**
participants lost weight

**0%**
amputations because of diabetes

**$3,185**
program savings per person per year

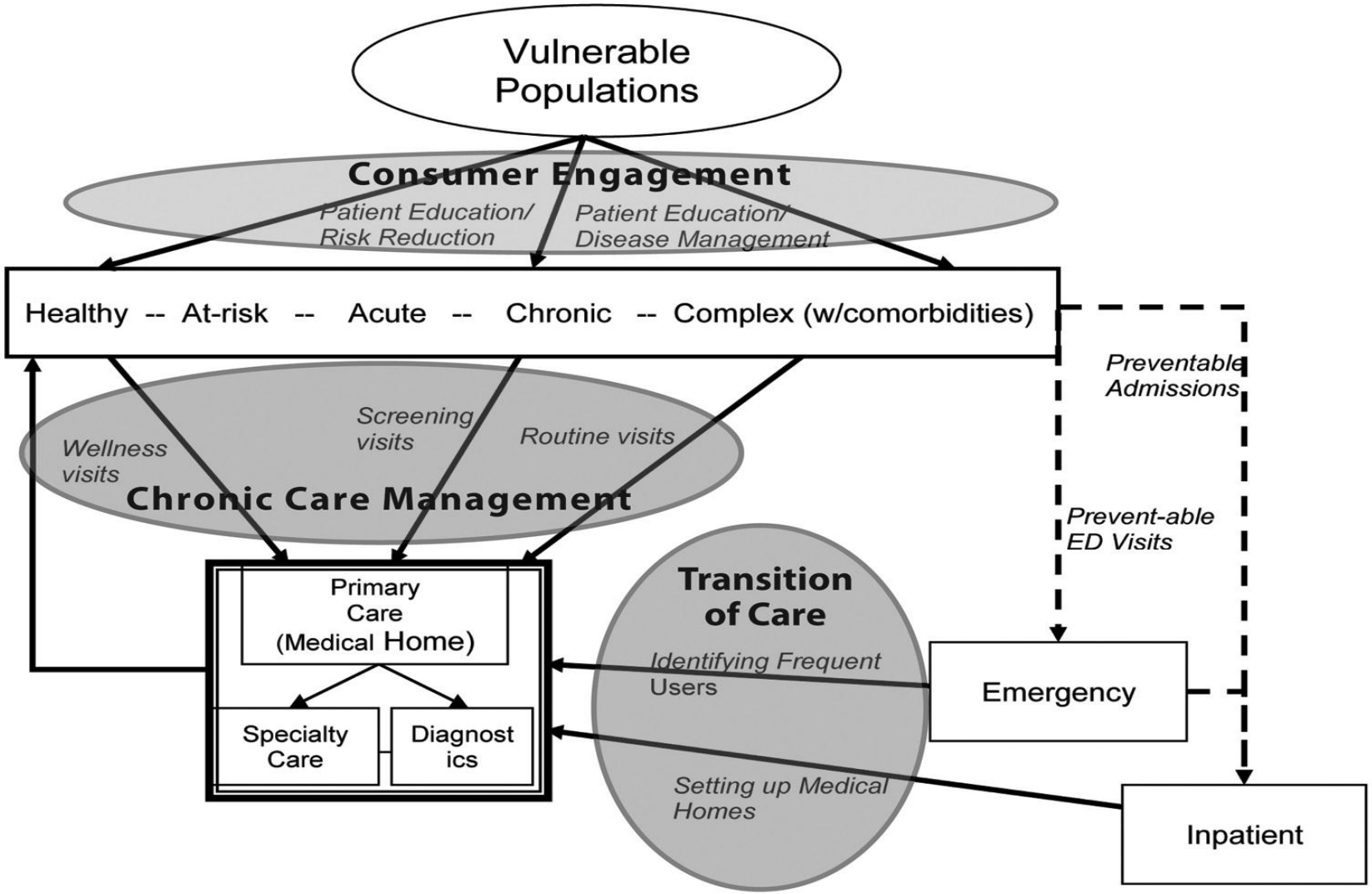
Crescent City Beacon Community

# Health System Redesign in NOLA

- Clear vision of patient-centered, accessible, high quality, **community**-based, and **accountable** health system
- Federal, state, local, and philanthropic support
- Strong, collaborative leadership facilitated by LPHI for achieving improved population health

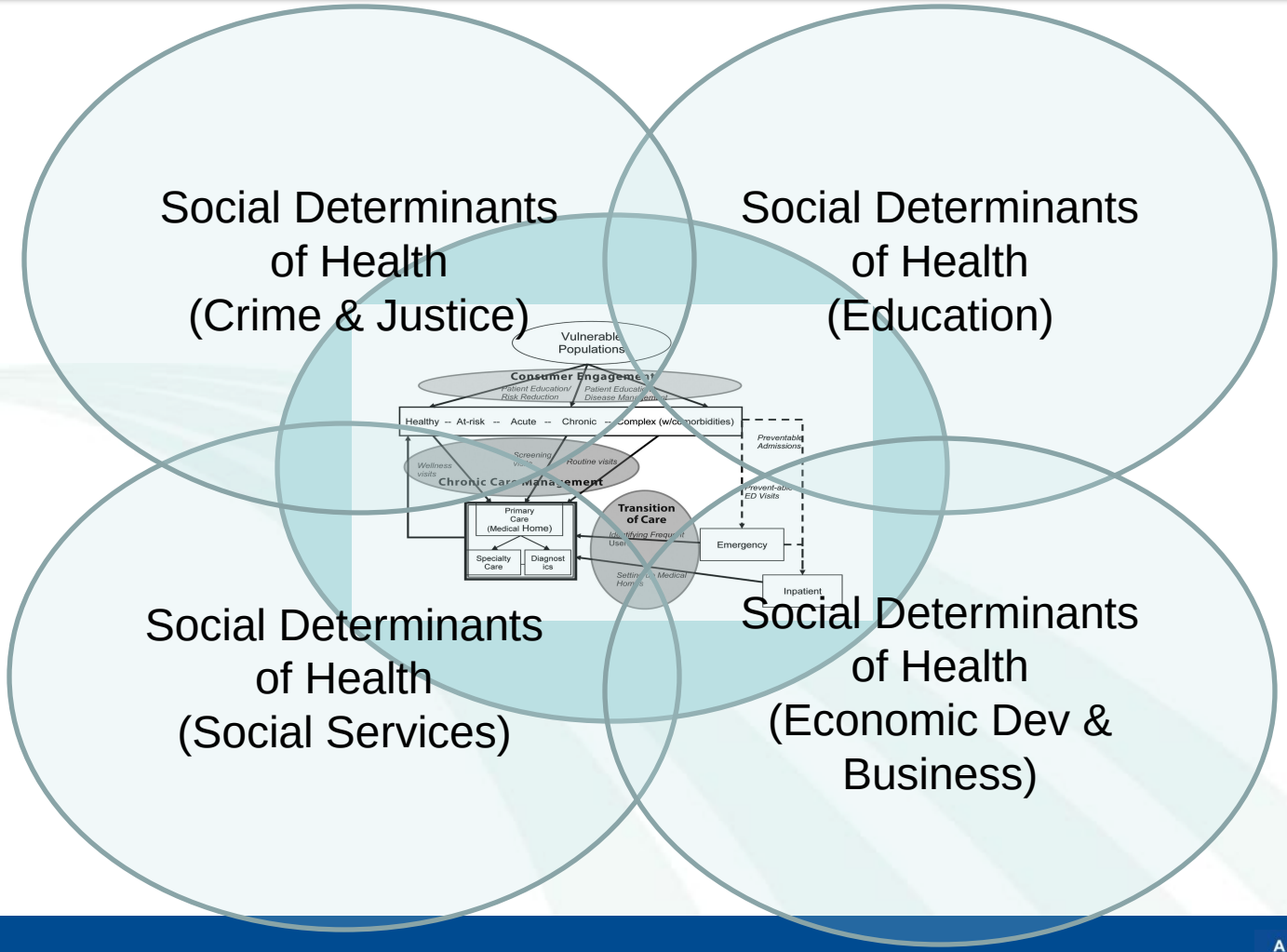
Crescent City Beacon Community

# Dynamic Framework for Coordinated System of Care

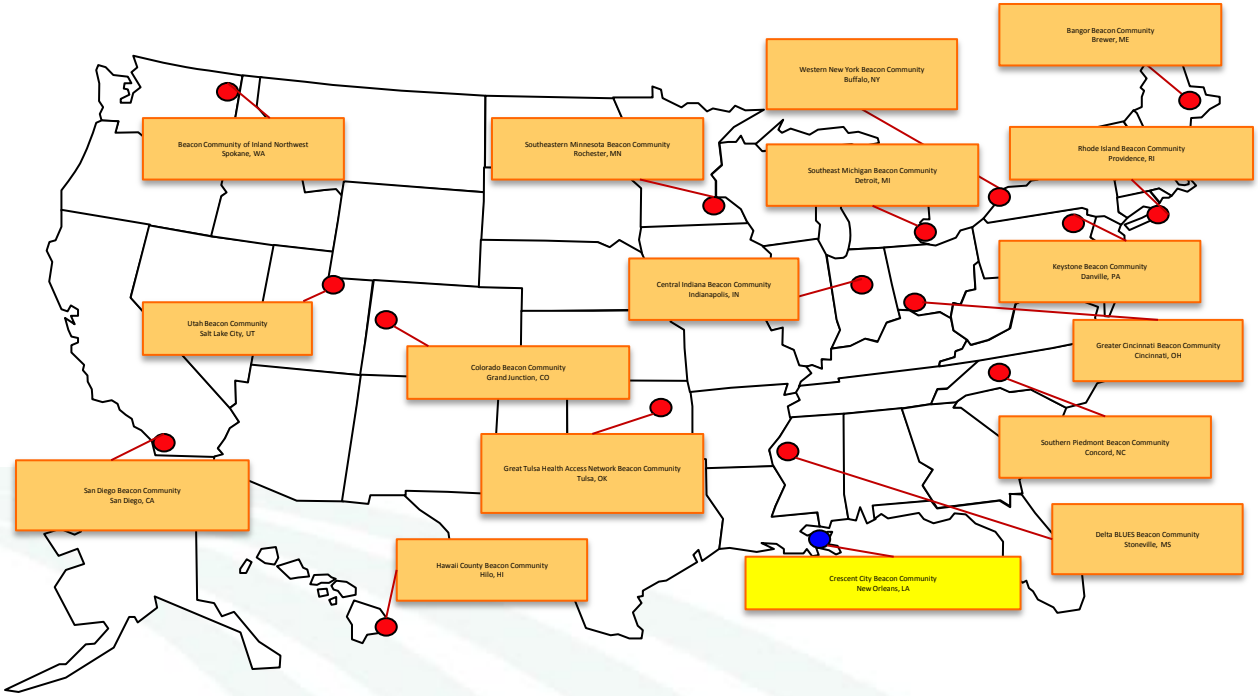


Crescent City Beacon Community

# System Integration to achieve health



Crescent City Beacon Community




# CRESCENT CITY BEACON COMMUNITY

Crescent City Beacon Community

# Beacon Community Goals

Reduced burden of chronic diseases, mainly diabetes and cardiovascular disease by:

- **Improving the quality of care** for chronic disease patients in patient-centered medical homes, enabled by HIT
- **Reducing healthcare costs** by decreasing preventable emergency department and inpatient visits through better coordination of care for chronic disease patients
- **Engaging consumers** in the healthcare process through innovative technologies

Crescent City Beacon Community

# CCBC Goals and Accomplishments

**Clinical Transformation**

***Improve Quality***

***16 primary care practices using team approach and process improvement for better patient outcomes***

**Care Coordination**

***Build & Strengthen HIT***

***Optimizing EMR and exchanging health information supporting clinician defined best practices***

**Consumer Engagement**

***Test Innovation***

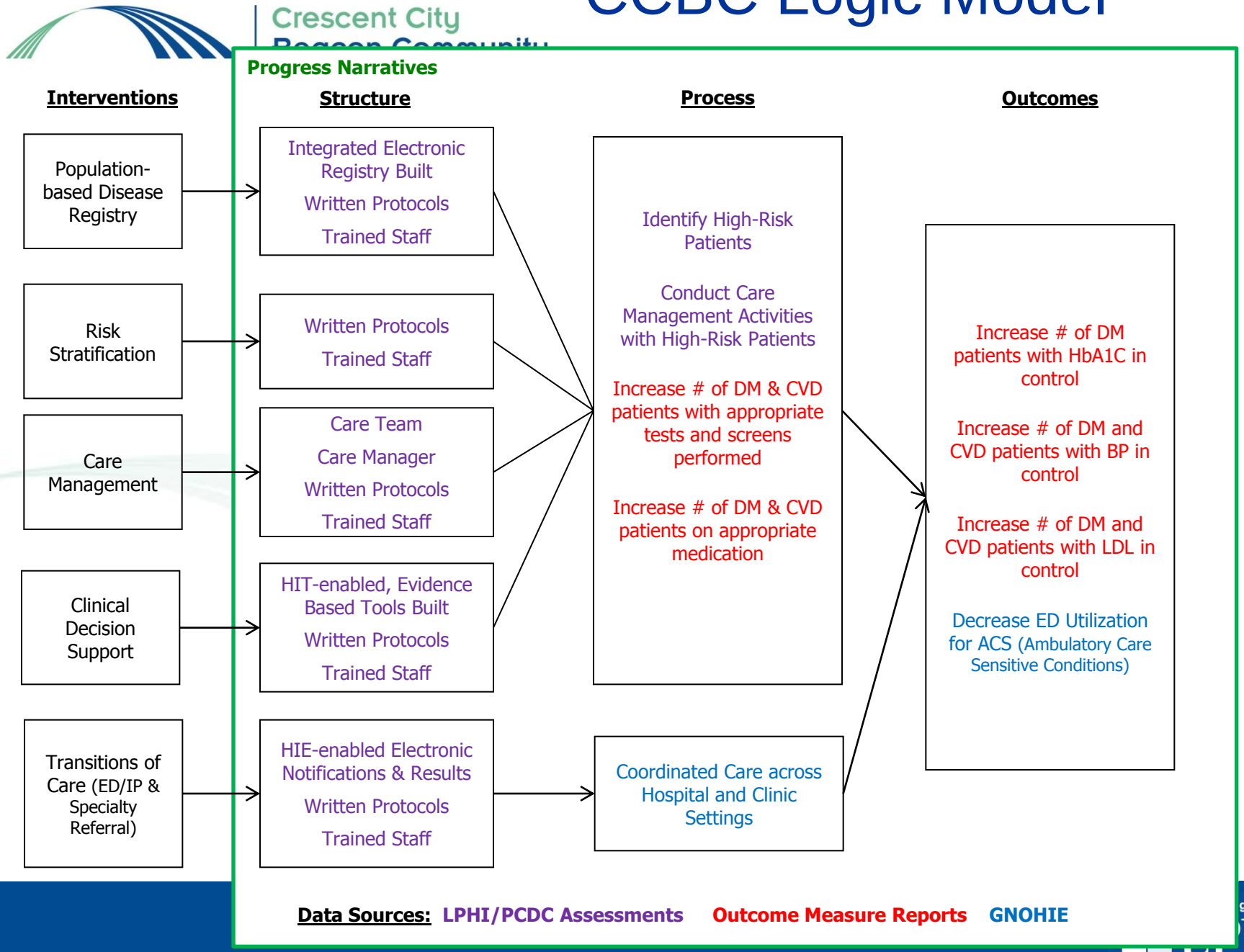
***mobile Text4Health technology to engage individuals in diabetes prevention and management***

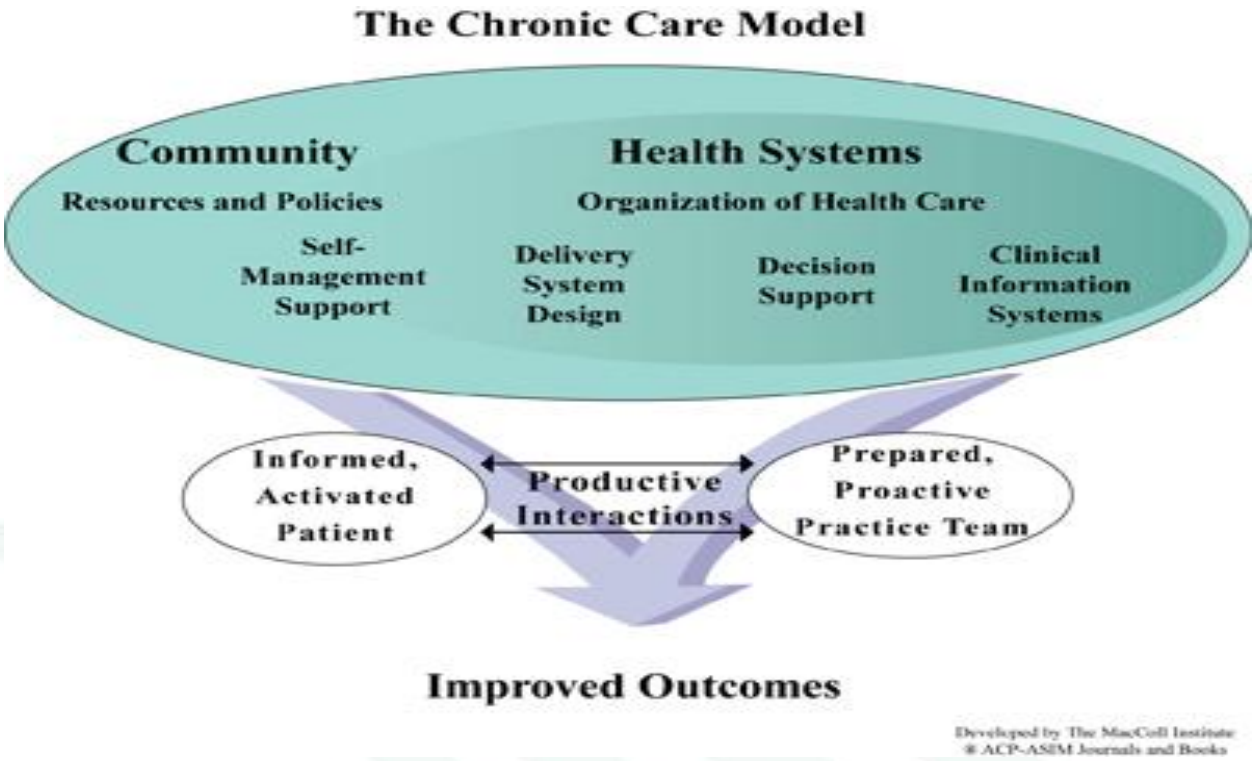
Crescent City Beacon Community

# Developmental Evaluation Model

- Developmental evaluation applies to an ongoing process of innovation in which both the path and destination are evolving
- evaluates innovative programs in real time by looking at the program as evolving, complex adaptive systems operating in complex, evolving settings
- through this framework, we categorized CCBC intervention components using the Structure-Process-Outcome model by Donabedian

# CCBC Logic Model






# CHRONIC CARE MANAGEMENT

Crescent City Beacon Community

# PCMH and Clinical Transformation

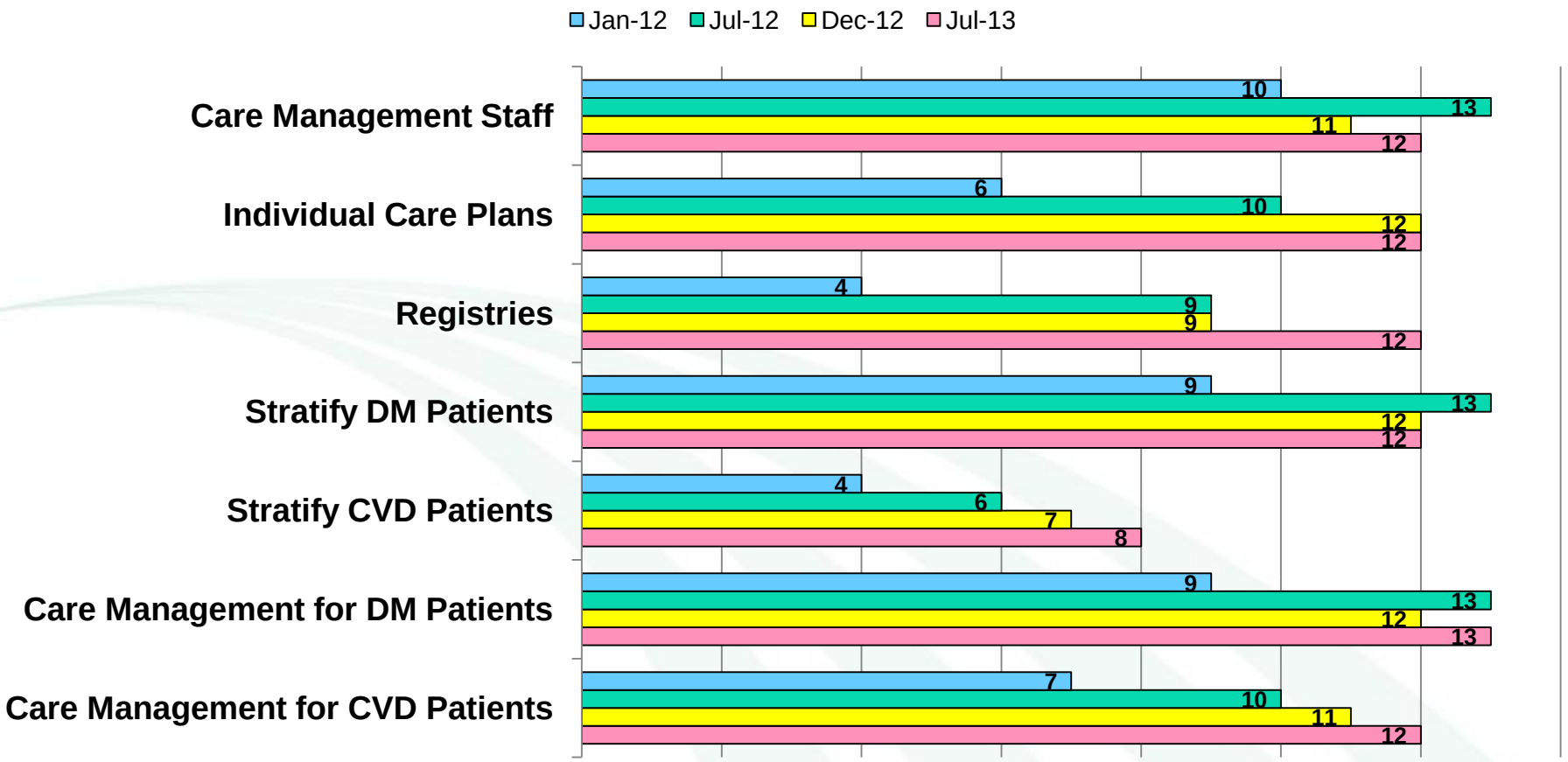
1. *population-based disease registries*
2. *risk stratification of patients*
3. *care management/care team strategies*
4. *clinical decision support systems*

| | | | | |
|---|---|---|---|---|
| **Practice Coaching** | **Learning Collaborative** | **EMR Optimization** | **NCQA Certification** | **Clinical Seminar Series** |

Crescent City Beacon Community

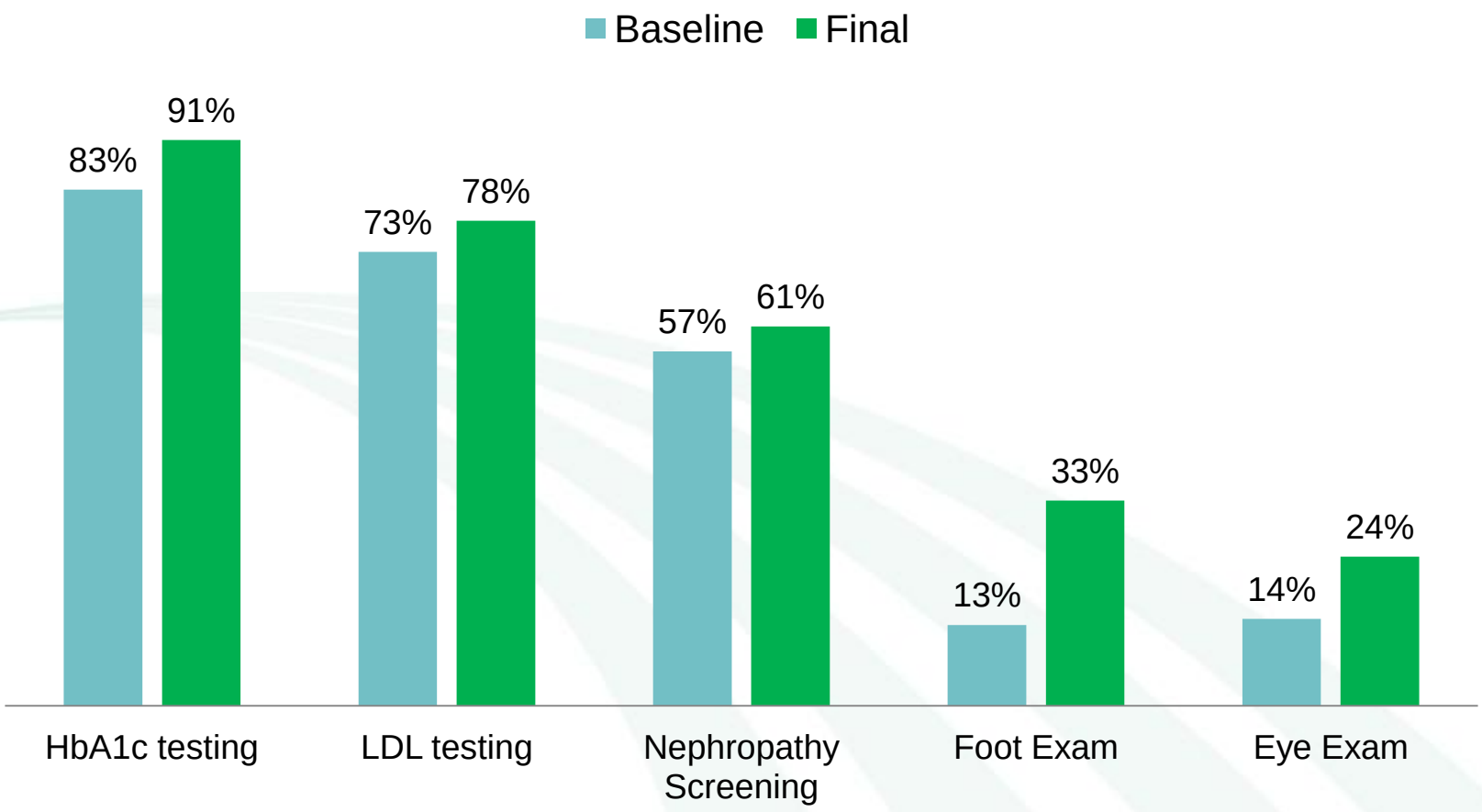
# Process Improvement

## SITES USING CARE MANAGEMENT PROCESSES: 2012-2013



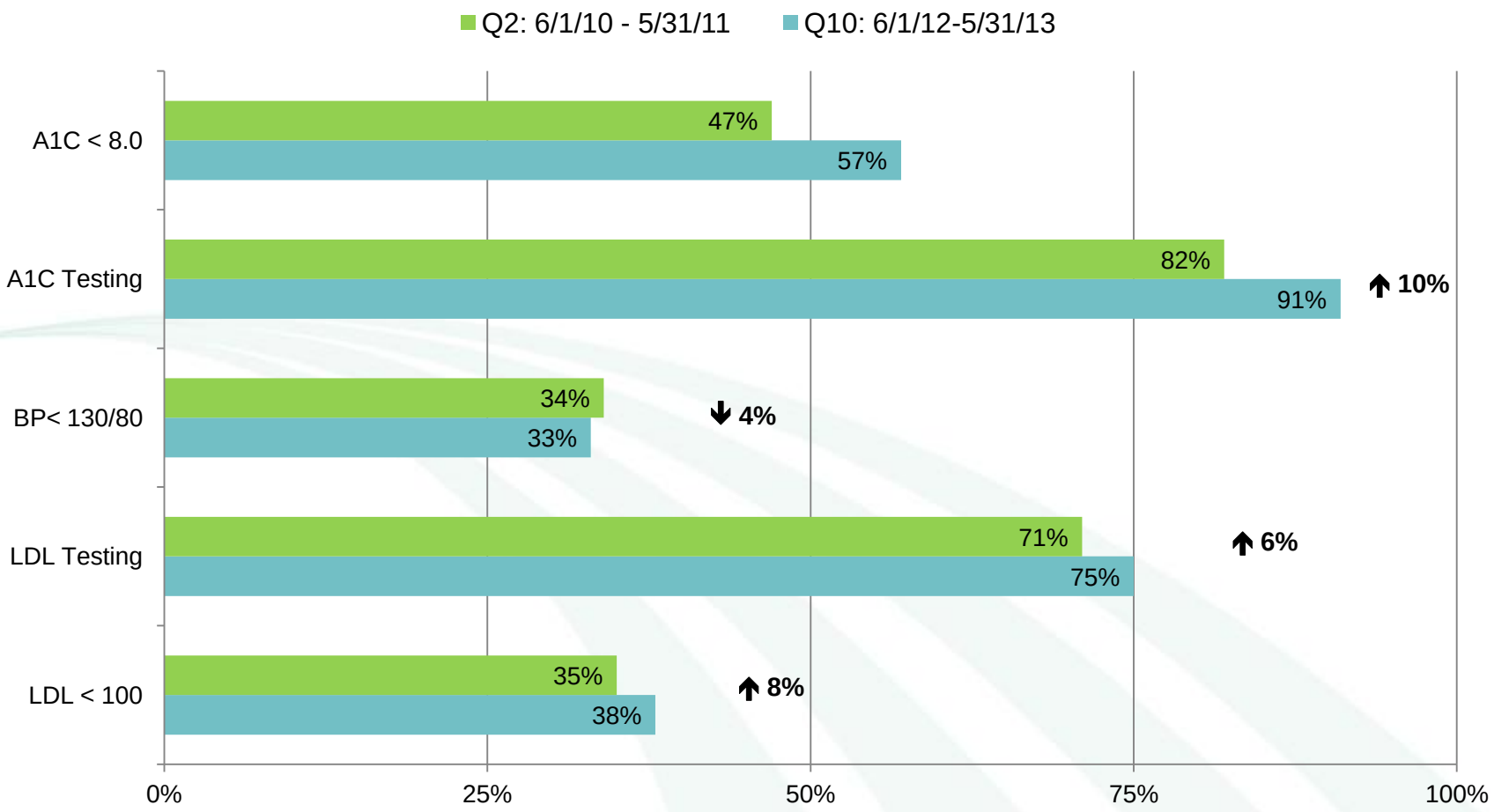
Crescent City Beacon Community

# Patients with Diabetes Receiving Recommended Tests



Crescent City Beacon Community

# Outcomes Improvement



Crescent City Beacon Community


# TRANSITIONS OF CARE

Crescent City Beacon Community

# Care Coordination

## GNOHIE

- Connect
- Match (EMPI)
- Secure Mail
- Results (CDR)
- NwHIN Gateway

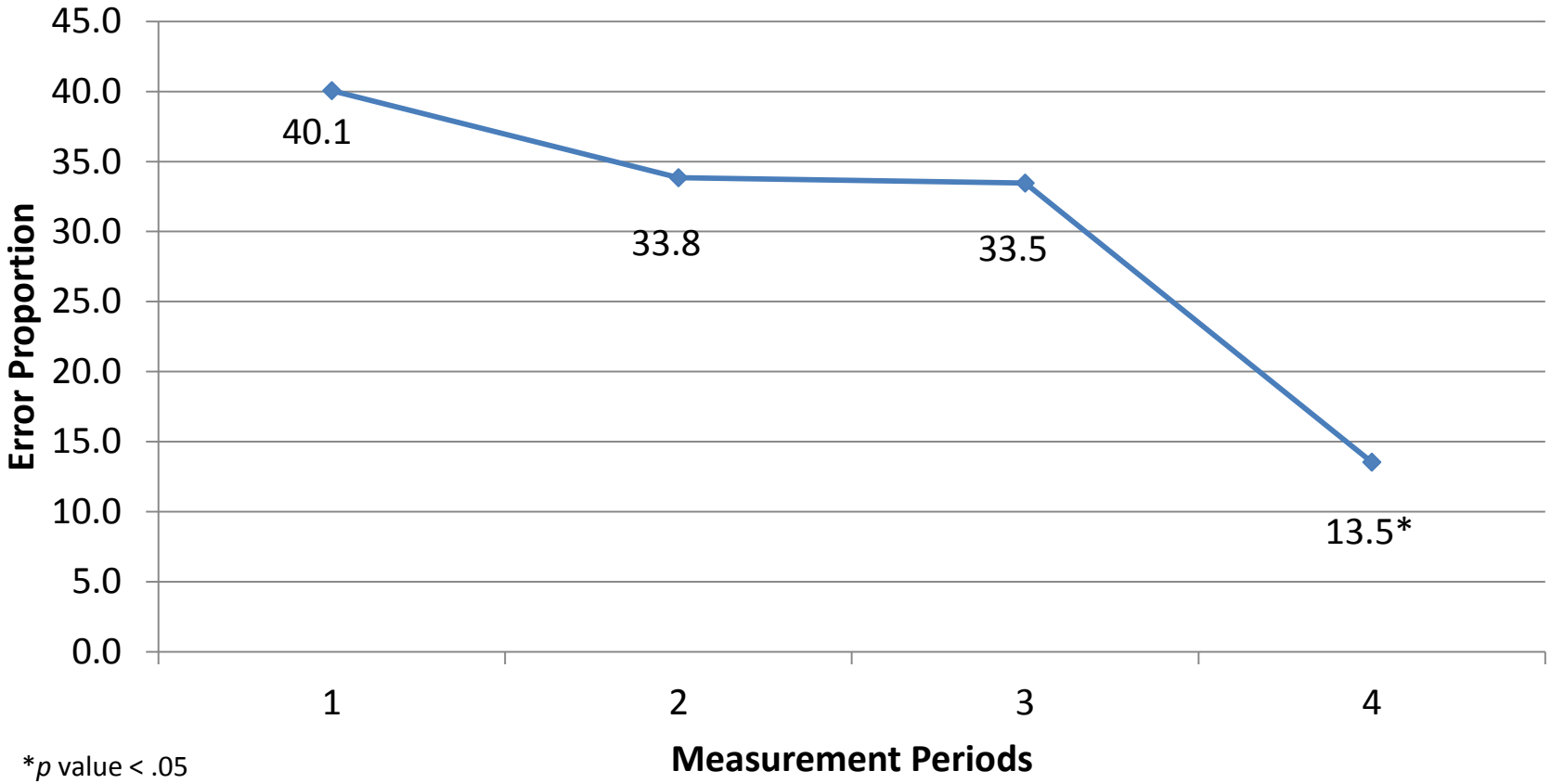
- **ED/IP Notification**
- **Electronic Specialty Care Referral**
- **Patient Portal**
- **Behavioral Health Integration**
- **Analytics**

# Common Measure Error Types

- Incorrect visit count parameters
- Use of non-standardized or highly customized order/CPT codes
- Non-structured lab data fields
- Practice management configurations for uninsured or non-billable visits
- Numerator miscalculation – inclusion criteria
- Denominator miscalculations

Crescent City Beacon Community

# Mean Data Error Proportions for Diabetes Mellitus Measures Among CCBC Clinics Over Time




**p* value < .05

Crescent City
Beacon Community

txt4health℠

# CONSUMER ENGAGEMENT

Crescent City Beacon Community

txt4health℠

# Consumer Engagement

**System collects:**

- HEIGHT
- WEIGHT (BMI)
- AGE
- GENDER
- FAMILY HISTORY
- DIABETES DIAGNOSIS
- SMOKING STATUS


**Enrollment**

**Development of Profile**
**(Risk Categorization)**

**System categorizes:**

- HIGH RISK
- LOW RISK

---

- UNDERWEIGHT
- AT WEIGHT
- OVERWEIGHT
- OBESE

**Goal Setting/Tracking**
**(Weight & Exercise)**

**Education/Motivation**
**(According to Risk)**

**Local Connections**
**(Care & Activities)**

Crescent City Beacon Community

# Engagement Campaign for txt4health

## Pre and Post Campaign Survey Results:

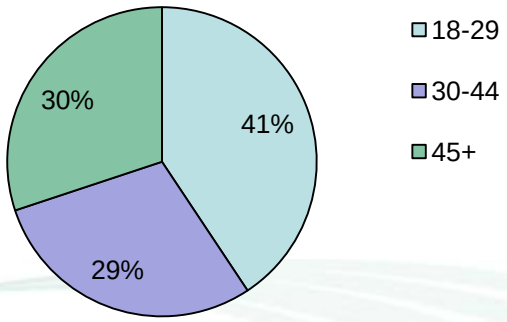
**Increase in awareness of txt4health campaign between the pre and post campaign survey, especially among priority audiences:**

| | |
|---|---|
| **4% → 19%** | awareness of txt4health among those with Type 2 Diabetes in their family |
| **8% → 29%** | awareness of txt4health among African Americans/Blacks |
| **9% → 29%** | awareness of txt4health among those under 30 years of age |

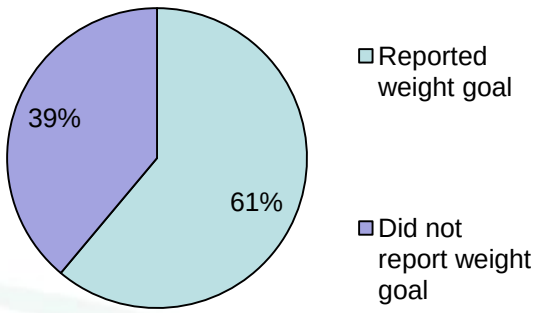
Crescent City Beacon Community

# Txt4health Program Results

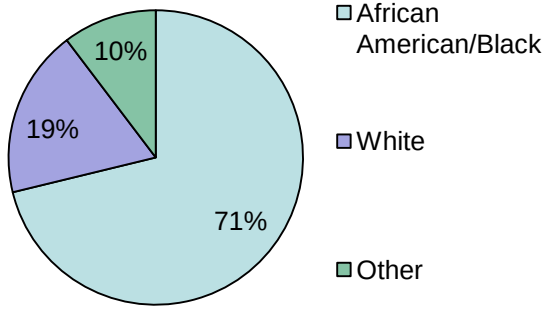
**Age distribution of participants who entered age (N=1060)**



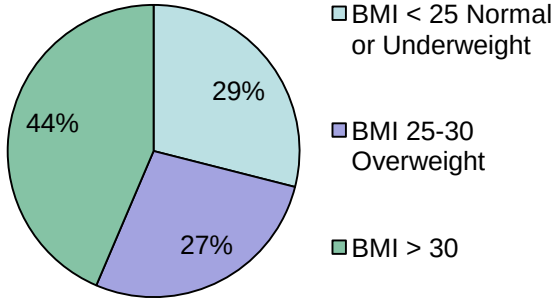

**Reported weight goal (N=1057)**



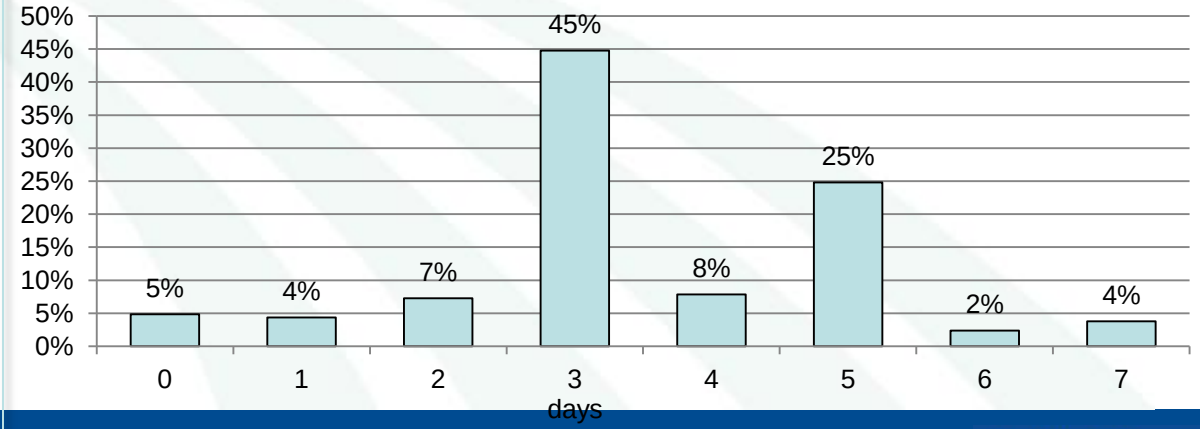

**Race/Ethnicity of those reporting (N=639)**




**BMI of participants who entered weight and height information (N=1395)**




**Reported active for at least 30 minutes a day (N=1431)**




An Affiliated Program of LPHI Louisiana Public Health Institute

Crescent City Beacon Community

# Governance Structure

**CCBC Steering Committee** (4 members)**:**
Oversight and strategy (LA DHH, City of New Orleans, BCBS LA, LPHI)

**CCBC Operating Board (**9 members):
Intervention operationalization (Selected partner hospitals and PCPs)

**GNOHIE Administrative Committee** (15 members -- one representative per GNOHIE member):
Provide oversight and decision-making regarding CCBC-related interventions/activities/infrastructure and address strategic planning, sustainability, and GNOHIE adoption after the conclusion of the CCBC funding period

**HIT Subcommittee**
- Information Security and Administration
- Infrastructure and Standards

**Clinical QI Subcommittee**
- Transitions of Care
- Chronic Care Management
- HIT Use Optimization
- Analytics & Reporting

**Sustainability Subcommittee**
- Intervention Sustainability
- Funding Sources

Crescent City Beacon Community

# Summary Project Timeline

Jun – Dec 2010: Formation of Operating Board; Discussions about alignment of partner needs; Slow start

Jan – Jun 2011: Formation of Steering Committee; Selection and prioritization of Interventions (CCM, TOC, CE); Pilot CCM in 5 clinic sites

Jul – Dec 2011: 1st Wave of CCM; Approval of GNOHIE set up; Planning and design of Txt4health; QI Subawards; Contract negotiations for CCM, TOC, and CE

Jan – Jun 2012: Formation of GNOHIE Administrative Committee; 2nd Wave & Clinical Coaching for CCM in 16 practices; Set up & functioning of GNOHIE for TOC; Launch of Txt4health

Jul 2012 – Sep 2013: Completion of CCM interventions; Fully operational GNOHIE; Txt4health reaches 1,800 enrollees; CCBC receives Health Care Informatics Innovation Award, 2013

Crescent City
Beacon Community

# CHALLENGES AND LESSONS

Crescent City Beacon Community

# CCBC to ACC

| ACC | CCBC |
|---|---|
| Integrated medical and public health models |  |
| Utilization of interprofessional teams |  |
| Collaboration among health systems and public health |  |
| A robust health information technology infrastructure |  |
| An integrated and fully mineable surveillance and data warehouse functionality |  |
| A dissemination infrastructure |  |
| A robust ACC implementation platform |  |
| Policy analysis and advocacy to facilitate ACC success and sustainability | |

Crescent City Beacon Community

# Shared Infrastructure for ACC

| Components | CCBC |
|---|---|
| Technology | Health Information Exchange; EMR optimization; Clinical Decision Support; mobile health technologies |
| Information | Exchange of standard information; Data Sharing Agreements; Data quality training; Central Data Repositories; Analytics; Social Services and Behavioral Health data |
| Process | Agreed protocols, guidelines and QI efforts; PCMH implementation and clinical coaching; ACO services; User feedback |
| People | Collaborative governance (GNOHIE Admin Com + Subcommittees); Trust; Vertical and horizontal integration; txt4health social campaigns; PATH (shared services) |


# 1. Community Ownership & Trust


























Crescent City Beacon Community

# 2. User-defined and Provider-led efforts

## Beacon Benefits

The team from our organization that participated in the Beacon Program have learned a great deal about care management and use of technology to achieve better health outcomes for our patients. It was an overall success for both our staff and patients.

Mark F.Keiser, MBA, MHA, MPH, FACHE,
Executive Director/CEO, Access Health Louisiana

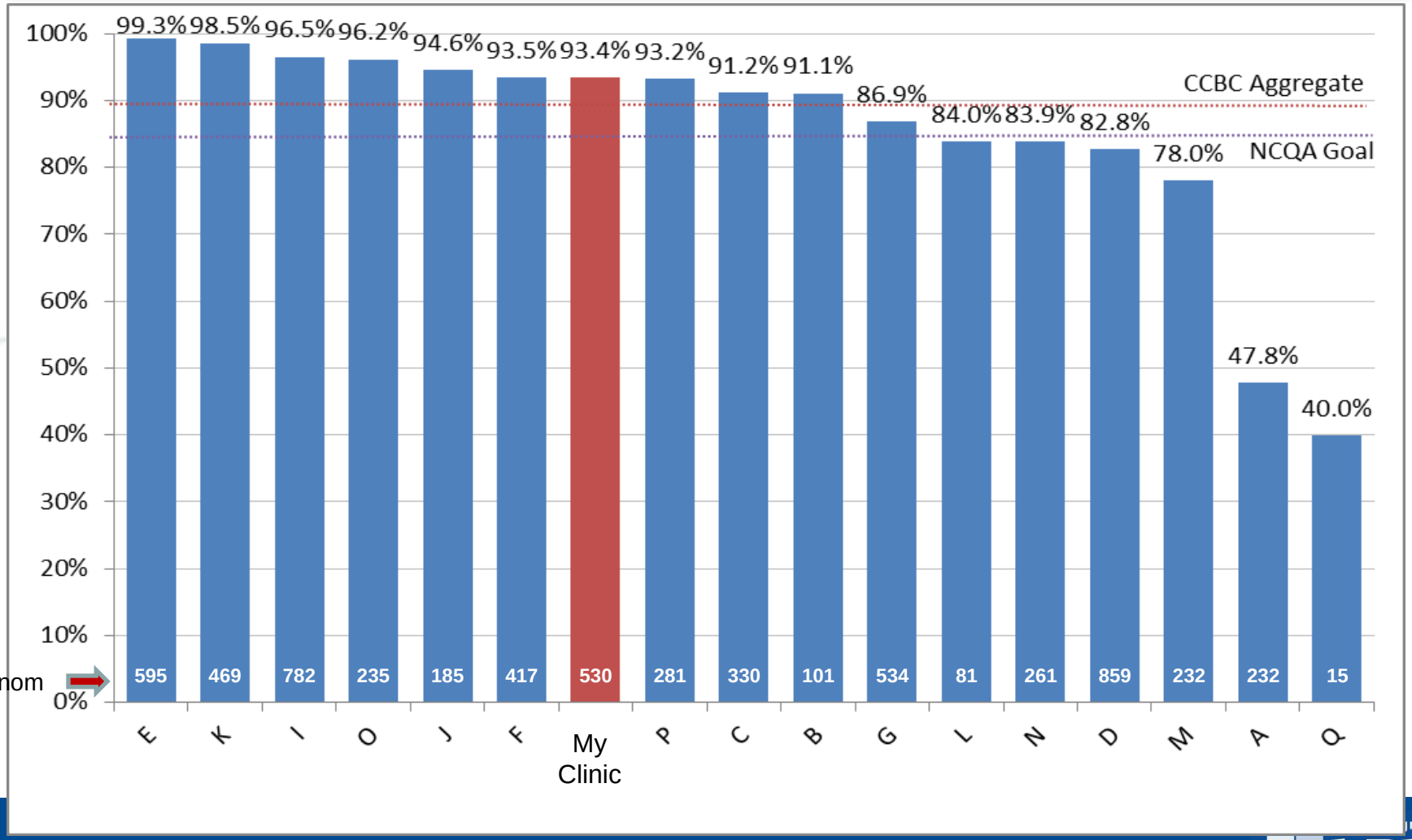
The CCBC initiative had facilitated the connection of community clinics network to specialty and tertiary care. It has helped to streamline smoother care coordination across the spectrum and established a framework for measurable quality matrixes.

Juzar Ali, MB.,BS (MD); FRCP(C); FCCP,
Chief Medical Officer, Interim LSU Hospital

Crescent City Beacon Community

# 3. Transparency & Accountability

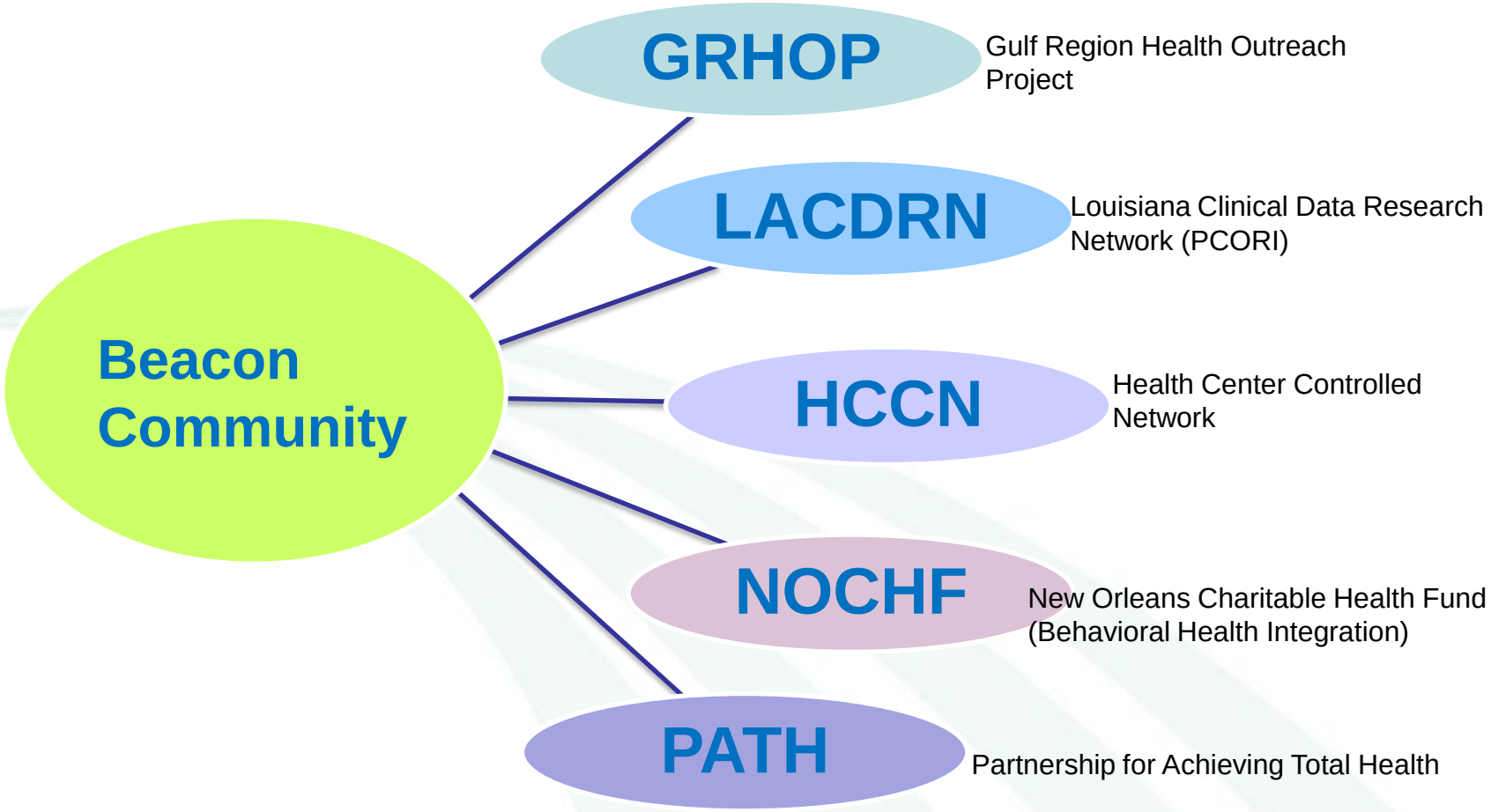
## DM QI Measure: HbA1c Testing



Crescent City Beacon Community

# 4. Plan Early for Sustainability

## Leveraging infrastructure



Crescent City Beacon Community

# 5. Focus on Patients

## Life on the Road . . .

**Patient History:**

- African American couple in their 40's
- Husband is a truck-driver and wife travels with him
- Husband diagnosed with diabetes (08/2012), would lose job if he had to use insulin
- Wife diagnosed with diabetes (02/2013)

**Treatment:**

- Couple enrolled in Care Management at time of diagnosis
- Invested in freezer and microwave in their cab to have healthier food options
- Began exercising more regularly
- Husband's **HbA1c decreased from >10 to 6.8**, he remains off insulin

*"She [care manager] has us sitting in the office like where she did a one-on-one, told us about the amount of food that we eat- what we can eat, what we can't eat. And about how to deal with it because it's hard being out here on the road."*

*"As long as I can continue to get the support from the clinic, everything is good."*

Crescent City Beacon Community

# Thank you

Anjum Khurshid
akhurshid@lphi.org