Supporting Transitions of Care in a CIN/ACO

What are CINs and ACOs?

- *Clinically Integrated Network:* A network of physicians who collectively commit to quality and cost improvement.

- *Accountable Care Organization:* A group of providers - including physicians, hospitals, post-acute providers - who are collectively responsible for the care outcomes of a patient population.

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From: O'Hara, Sarah. "The Care Transformation Alphabet: What's the Difference between CI, ACO, and PCMH?" What's the Difference between CI, ACO, and PCMH? Advisory Board, 24 Sept. 2014. Web. 04 June 2016.

What are the typical payer arrangements?

Maintaining quality as measured by identified clinical care metrics.

Savings as measured by a reduction in health care costs. (PMPM)

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CNY AIM

Central New York Accountable, Integrated Medicine is the Clinically Integrated Network

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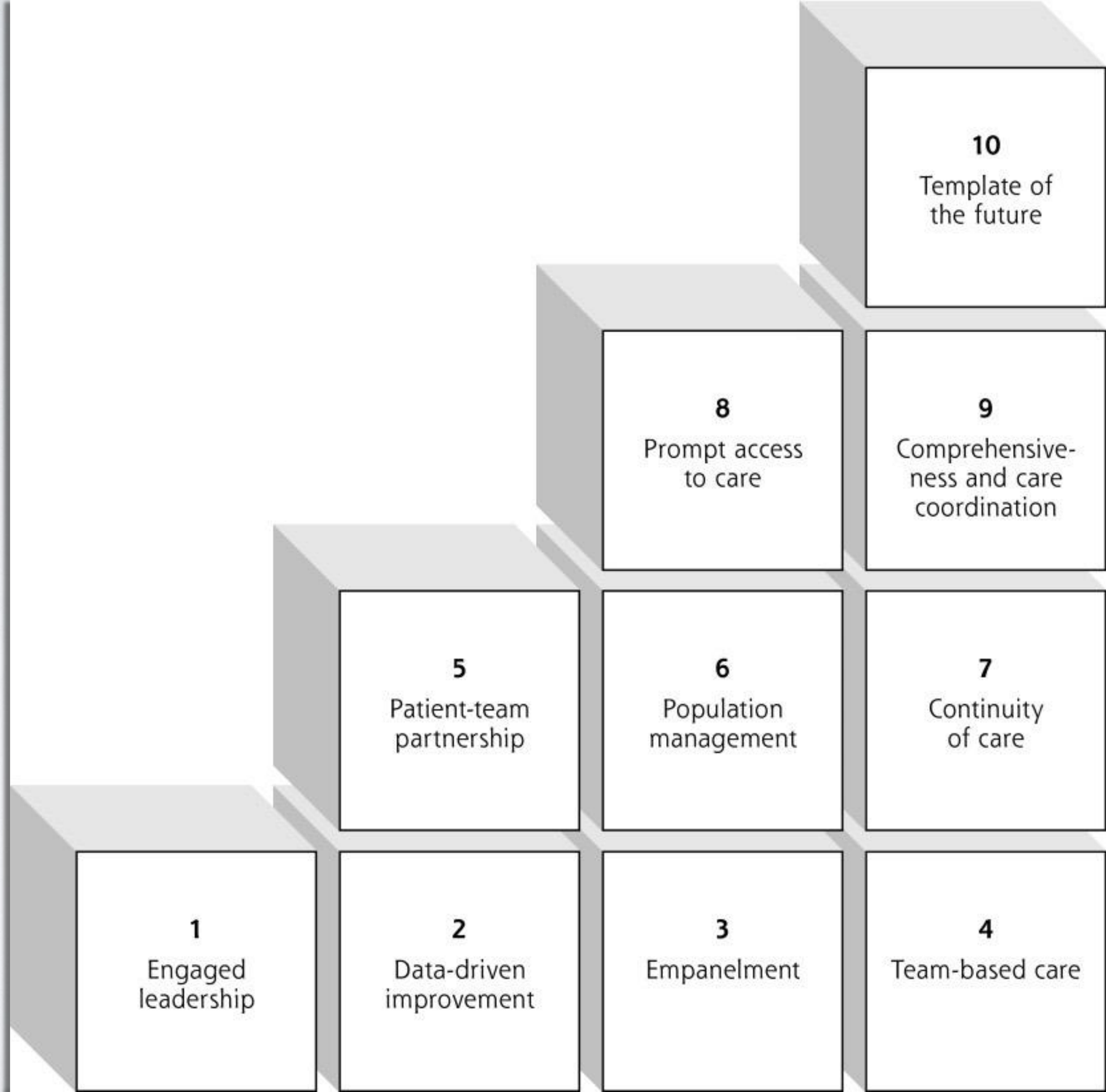
St. Joseph's Health Accountable Care Organization is the Accountable Care Organization

The 10 Building Blocks of High Performing Primary Care



From: Bodenheimer, Thomas, Amireh Ghorob, Rachel Willard-Grace, and Kevin Grumbach. "The 10 Building Blocks of High-Performing Primary Care." Annals of Family Medicine 12.2 (March/April 2014): 166-71. Print.

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Population Health Management is key.

- Panel management
- Supporting health maintenance
- Complex care management

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Not all patients need the same intervention.

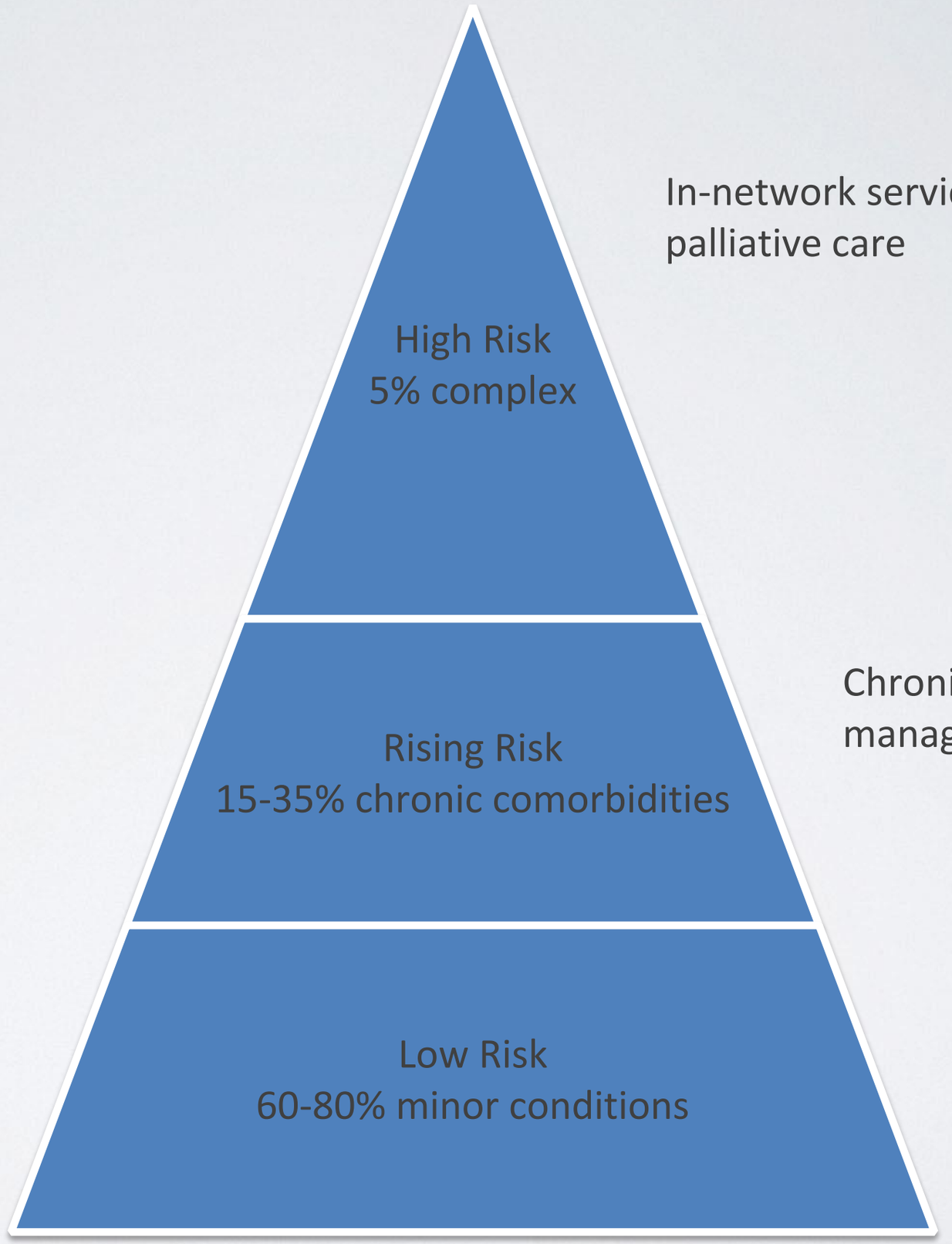
Patient Activation

1
Starting to take a role

2
Building knowledge & confidence

3
Taking Action

4
Maintaining behaviors

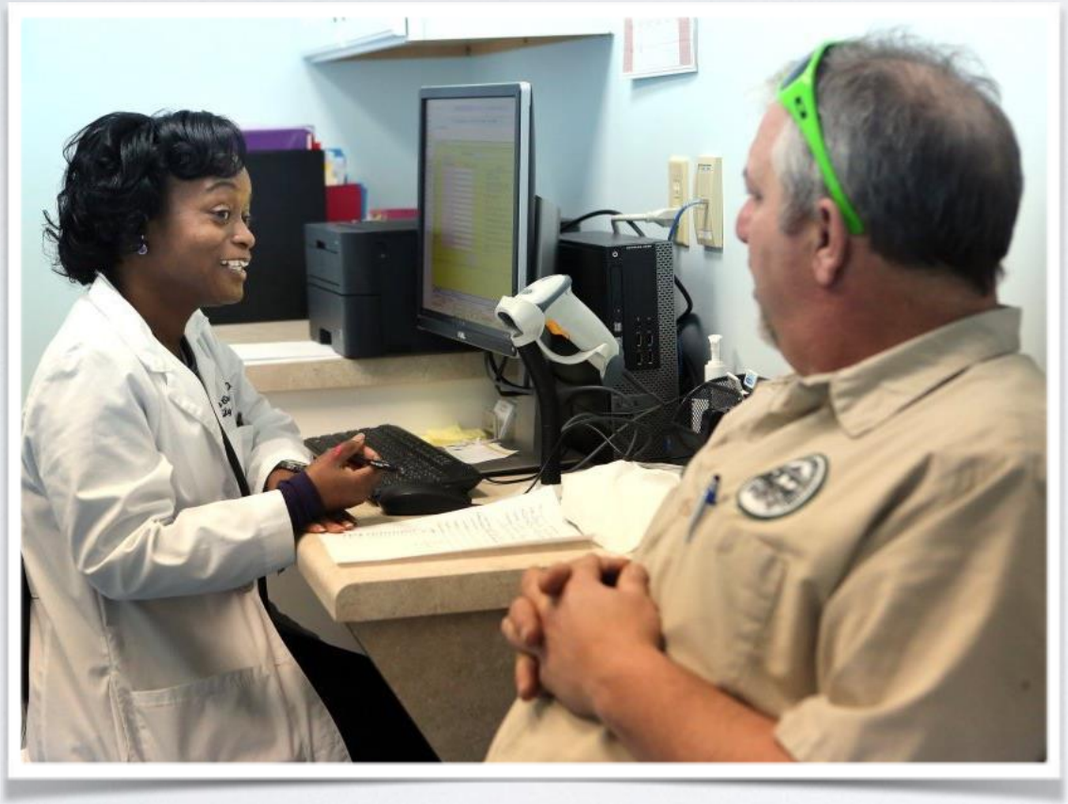


In-network services, palliative care

Chronic care management

Health maintenance

Transitions for this patient?



- 50 year old male
- Diabetes, depression
- PAM Level 2
- Regular exams – PCP
- Possible specialist visits - Endo, psych
- Labs and other health maintenance
- Pharmacy - perhaps multiple?
- ED or hospital admissions

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Patient Navigator

- Preparation in healthcare administrative functions.
- Using patient registries, identify patients in need of health maintenance care.
- Assist patients in navigating the health care system.

Working proactively from data.

Date: **5/17/2016**

		Progress			Snapshot	
		3/14/2016		5/17/2016	0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%	All ACQA
1	Adolescent Immunizations	57.30%	9.36%	66.67%		65.63%
2	Childhood Immunizations	53.19%	46.81%	100.00%		67.39%
3	Lead Screen	70.21%	29.79%	100.00%		76.09%
4	Breast Cancer Screen	67.98%	17.18%	85.16%		76.86%
5	Colorectal Cancer Screen	67.55%	9.32%	76.87%		71.00%
6	DM Nephropathy	76.64%	12.84%	89.47%		81.17%
7	DM A1c <= 9.0	15.82%	45.58%	61.40%		63.90%
8	DM A1c < 8.0	7.79%	30.81%	38.60%		48.21%
9	DM BP Control	18.05%	36.34%	54.39%		63.12%
10	DM Eye Exam	8.28%	19.79%	28.07%		18.16%
11	HTN BP Control	15.75%	35.57%	51.33%		60.26%

Percentile Group

		Breakdown				Needed for 90th		Opportunities for Gapped		
		Number Gapped	Number Compliant	Total	Percentile Group	Total	Per Week*	Total Gapped	Missed Opportunities	Open Opportunities
1	Adolescent Immunizations	1	2	3	25th	1	0.06	1	0	1
2	Childhood Immunizations	0	1	1	90th			0	0	0
3	Lead Screen	0	1	1	90th			0	0	0
4	Breast Cancer Screen	27	155	182	90th					
5	Colorectal Cancer Screen	71	236	307	90th					
6	DM Nephropathy	6	51	57	75th	1	0.06			
7	DM A1c <= 9.0	22	35	57	< 25th	10	0.60			
8	DM A1c < 8.0	35	22	57	< 25th	17	1.02			
9	DM BP Control	26	31	57	< 25th	13	0.78			
10	DM Eye Exam	41	16	57	< 25th	25	1.50			
11	HTN BP Control	110	116	226	< 25th	54	3.23			

*Target date 10/1/2016

ST. JOSEPH'S Health
A Higher Level of Care

Nurse Coach

- RN, Bachelor's or Master's prepared
- Works with "high/rising risk" patients
- Patient activation, coordination of care

Nurse Health Coach Outcomes
(An Initial Look)

Diabetes			
Patients with A1c ≥9.0 at baseline	82	Percent of patient with decrease	67%
Patients with A1c 8 > 9 at baseline	38	Percent of patients with increase	30%
Patients with a baseline and follow up	70	Percent of patients with no change	3%
Hypertension			
Patients with BP > 140/90 at baseline	91	Percent of patients with decrease	82%
Patients with baseline and follow up	78	Percent of patients with increase	18%

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The Five Roles of Health Coaching and Patient Navigation

Self-management support	Bridge between clinician and patient	Navigation of the health care system	Emotional support	Continuity
• Teaching disease-specific skills, problem solving • Promoting behavior change • Encourage participation	• Serving as patient's liaison • Ensuring patient understands and agrees with care plan • Providing cultural competence	• Connecting the patient with resources • Facilitating support • Ensuring patient's voice is heard	• Showing interest and inquiring about emotional issues • Teaching coping skills	• Providing familiarity • Following up • Establishing trust • Being available

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Adapted From: Bennett, Heather D., Eric A. Coleman, Carla Parry, and Thomas Bodenheimer. "Health Coaching for Patients with Chronic Illness." Family Practice Management (September/October 2010): 24-29. Web.

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