2024 Dakota Conference On Rural and Public Health

Call to Action
Partnerships for Community Health

June 5, 2024

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

Great Plains Quality Innovation Network

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Objectives

1. Discuss current landscape of healthcare collaboration in North Dakota
2. Describe how to identify disparities and opportunities in your community
3. Share innovative methods to improve care coordination

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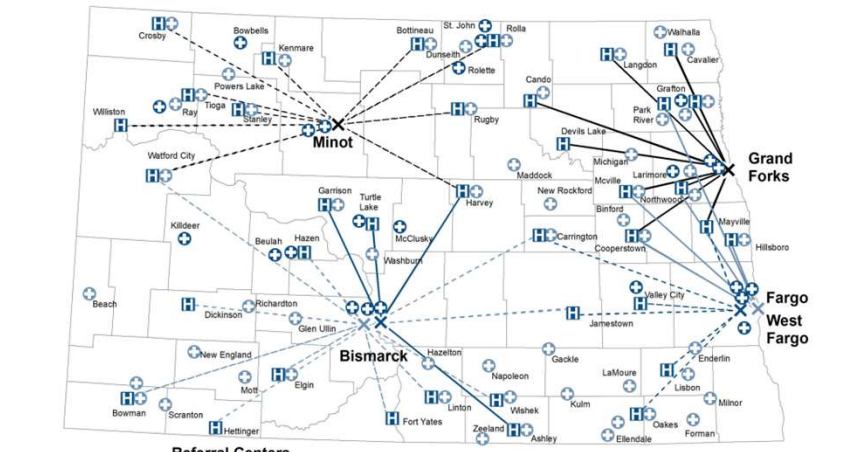
Critical Access Hospitals, Rural Health Clinics, and Federally Qualified Health Centers
North Dakota, 2022



Referral Centers

- Altru Health Systems Grand Forks
- CHI St. Alexius Bismarck
- Sanford Health and CHI St. Alexius Bismarck
- Sanford Health Fargo
- Sanford Health and Essentia Health Fargo
- Trinity Hospital Minot

- Referral Center
- Critical Access Hospital
- Federally Qualified Health Center
- Rural Health Clinic

The Rural Health Clinic Services Act of 1977 (Public Law 95-210) was enacted to address an inadequate supply of physicians serving Medicare patients in rural areas and to increase the use of non-physician practitioners such as nurse practitioners (NPs) and physician assistants (PAs) in rural areas.

Sources: data.HRSA.gov, April 2022

Created by the North Dakota Healthcare Workforce Group on 4/2022

UND School of Medicine & Health Sciences, University of North Dakota
ND Healthcare Workforce Group
Center for Rural Health, University of North Dakota School of Medicine & Health Sciences

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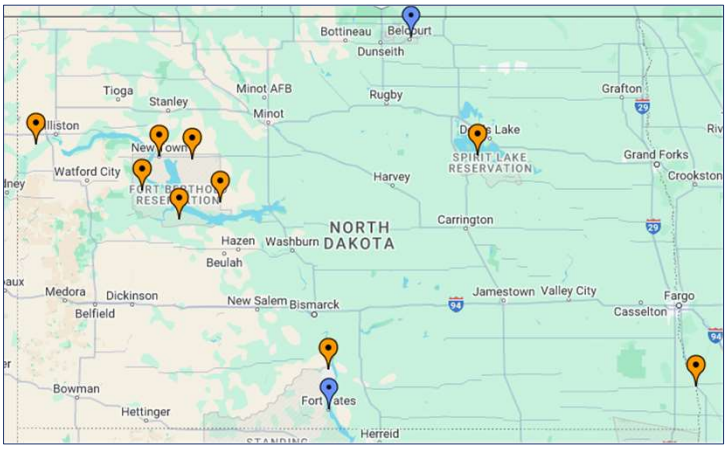
IHS Hospitals and Tribal Health Centers



- IHS hospital
- Tribal Health Center

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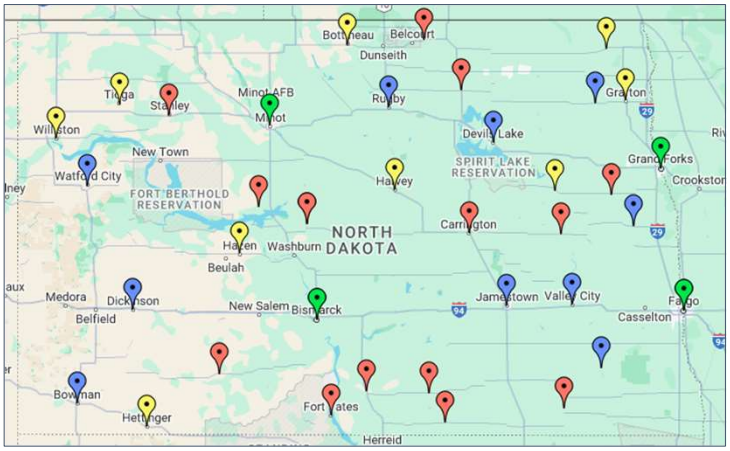
North Dakota Cardiac Rehab Sites



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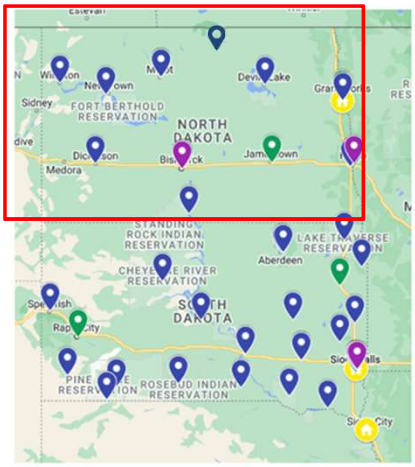
Kidney Dialysis Units in the Dakotas

- 4 Transplant Centers
- 30 In-center dialysis units
- 3 Home dialysis units
- 10 In-center/home dialysis units

- About 80% of ND/SD facilities are independent or regional chains

- 1,954 dialysis patients receive care in ND & SD facilities (as of 7/18/2023)
  - 1,579 incenter
  - 375 home

- 32% of dialysis patients in ND & SD are American Indian/Alaska Native
- 37% live in rural areas



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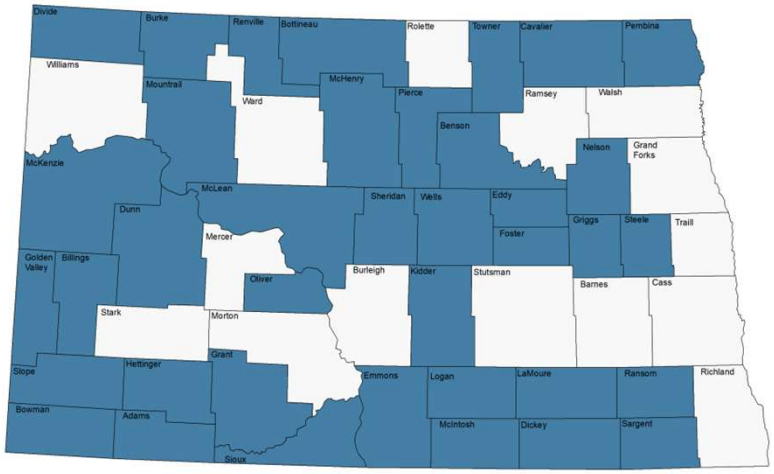
North Dakota Frontier Counties



Center for Rural Health
University of North Dakota
School of Medicine & Health Sciences

38 of 53 North Dakota counties designated as frontier*
*Less than 7 persons per square mile

Source: U.S. Census Bureau, ACS 2018 5-Year Estimates

Created by the North Dakota Healthcare Workforce Group on 2/2020

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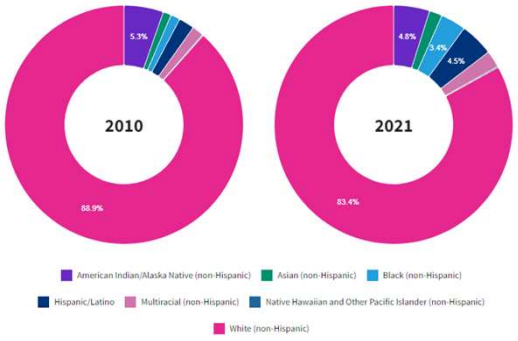
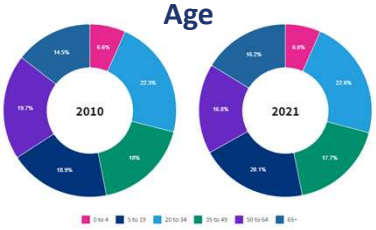
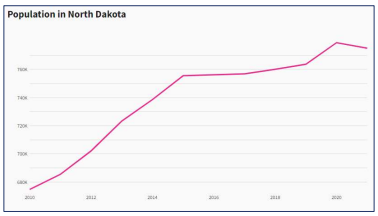
ND Population Characteristics

Race



Age





Data Source: United States Census Bureau

https://usafacts.org/data/topics/people-society/population-and-demographics/our-changing-population/state/north-dakota?endDate=2021-01-01&startDate=2010-01-01

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Additional Disparities
Life Expectancy and Chronic Disease

A silent crisis is occurring across American Indian and Alaska Native populations. Early death robs families, tribes, and generations of their culture, kinship systems, and lineage.

In 2021, American Indian and Alaska Native **life expectancy at birth was 65.2 years**, the lowest of any racial or ethnic group in the US and 10 years less than that of the general population. Advances in public health, policy, and medicine during the last 79 years have not equitably increased American Indian and Alaska Native life expectancy.
American Indian and Alaska Native Life Expectancy: Writing a New Narrative | Health Policy | JAMA | JAMA Network

Rural African American and American Indian/Alaska Native adults are **more likely to have multiple chronic health conditions** than non-Hispanic White rural adults.

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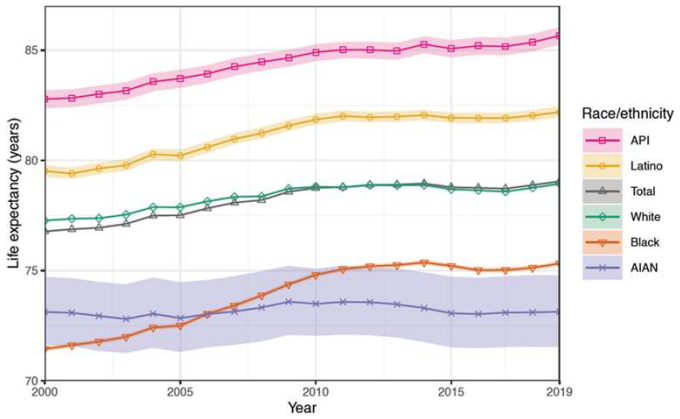
National Life Expectancy by Racial/Ethnic Group, 2000–2019



National life expectancy at birth by year and racial/ethnic group for 2000–2019. Solid lines indicate the mean estimates, and shaded areas indicate 95% uncertainty intervals.
Life expectancy by county, race, and ethnicity in the USA, 2000–19: a systematic analysis of health disparities - The Lancet

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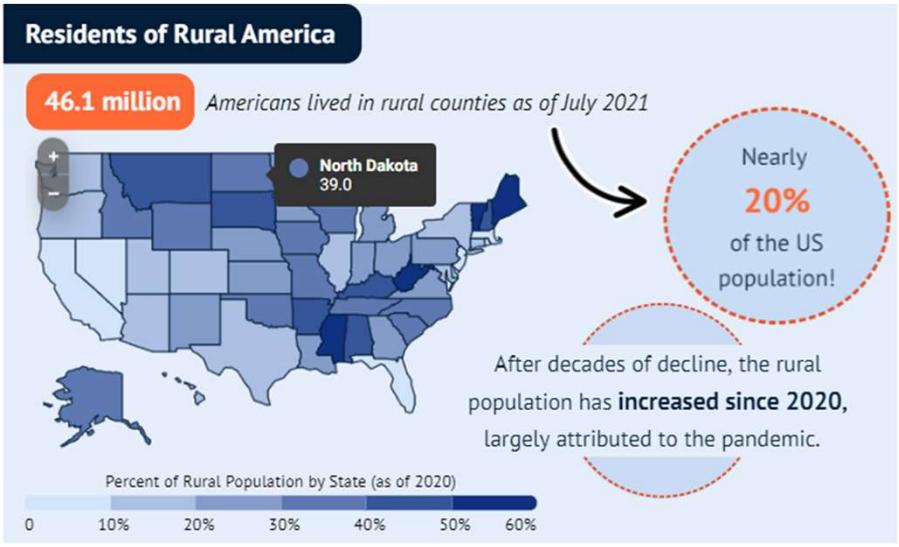

Rural Health: Addressing Barriers to Care (nihcm.org)

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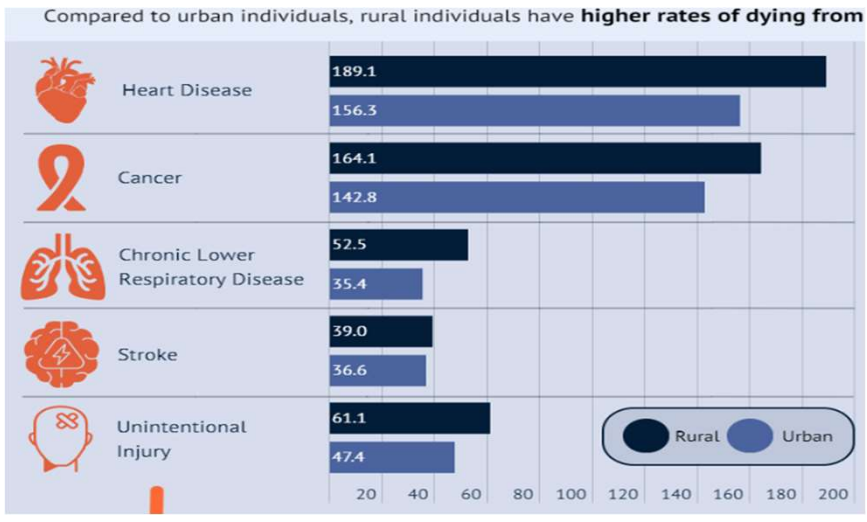

Rural Health: Addressing Barriers to Care (nihcm.org)

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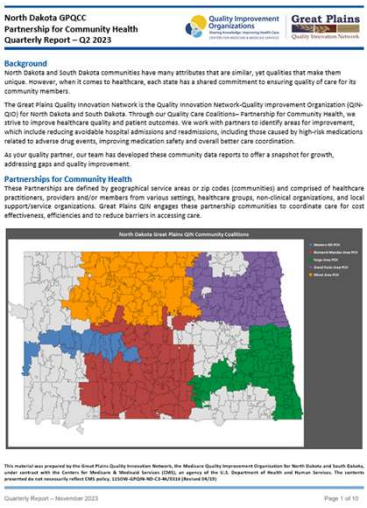
Partnership for Community Health Report


North Dakota GPQCC
Partnership for Community Health
Quarterly Report – Q2 2023

Quality Improvement Organizations | Great Plains QIN

Background

North Dakota and South Dakota communities have many attributes that are similar, yet qualities that make them unique. However, when it comes to healthcare, each state has a shared commitment to ensuring quality of care for its community members.

The Great Plains Quality Innovation Network is the Quality Innovation Network-Quality Improvement Organization (QIN-QIO) for North Dakota and South Dakota. Through our Quality Care Coalitions– Partnership for Community Health, we strive to improve healthcare quality and patient outcomes. We work with partners to identify areas for improvement, which include reducing avoidable hospital admissions and readmissions, including those caused by high-risk medications related to adverse drug events, improving medication safety and overall better care coordination.

As your quality partner, our team has developed these community data reports to offer a snapshot for growth, addressing gaps and quality improvement.

Partnerships for Community Health

These Partnerships are defined by geographical service areas or zip codes (communities) and comprised of healthcare practitioners, providers and/or members from various settings, healthcare groups, non-clinical organizations, and local support/service organizations. Great Plains QIN engages these partnership communities to coordinate care for cost effectiveness, efficiencies and to reduce barriers in accessing care.

North Dakota Great Plains QIN Community Coalitions

This material was prepared by the Great Plains Quality Innovation Network, the Medicare Quality Improvement Organization for North Dakota and South Dakota, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 11SOW-GPQIN-ND-CS-#LT0324 (Revised 04/19)

Quarterly Report – November 2023 Page 1 of 10

Data Source used in Report:

- Medicare FFS claims data
- Excludes COVID-19 related claims

Evaluation of data pertaining to:

- Hospital Admissions
- Hospital Readmissions
- Acute Care Utilization
- Top 5 diagnoses* for Hospital Admissions
- Top 5 diagnoses* for 30-Day Readmissions
- ED Visits
- other

https://greatplainsqin.org/initiatives/care-transitions/

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Top Diagnoses

Admissions
10/1/2022 – 9/30/2023

Community	DRG Bundle Description
Bismarck-Mandan Area	Septicemia or Severe Sepsis
	Heart Failure and Shock
Fargo Area	Septicemia or Severe Sepsis
	Heart Failure and Shock
Grand Forks Area	Septicemia or Severe Sepsis
	Heart Failure and Shock
Minot Area	Septicemia or Severe Sepsis
	Simple Pneumonia and Pleurisy
Western ND	Septicemia or Severe Sepsis
	Heart Failure and Shock

Readmissions
10/1/2022 – 9/30/2023

Community	DRG Bundle Description
Bismarck-Mandan Area	Septicemia or Severe Sepsis
	Heart Failure and Shock
Fargo Area	Heart Failure and Shock
	Septicemia or Severe Sepsis
Grand Forks Area	Septicemia or Severe Sepsis
	Heart Failure and Shock
Minot Area	Septicemia or Severe Sepsis
	Heart Failure and Shock
Western ND	Simple Pneumonia & Pleurisy
	Kidney and Ureter Procedure

DRGs that differ only in their level of complications are combined into "DRG Bundles" as designated by Great Plains QIN. For example, DRGs 637, 638, and 639 (Diabetes with major complications, with complications, and without complications) are combined into one DRG bundle called Diabetes.

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Drivers of Healthcare Utilization in ED

Super-utilizer/Multi-Visit Patient or MVP

- High number of ED, IP, Observation visits
- A 'MVP' classification is based on the prior year's utilization, which included at least 4 inpatient claims or at least 5 emergency department (ED), observation stay (ObS) and inpatient (Inp) claims combined.

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Multi-Visit Patient Analysis

***Medicare FFS Claims Data**

MVP Group 1	MVP Group 2
▪ Average age 55 yrs. old ▪ Extremely high utilization ▪ Behavioral Health and/or Substance Use Disorder diagnoses ▪ 30% of MVPs, nearly half of total overall visits	▪ Average age 69 yrs. old ▪ Lower utilization ▪ Characteristics are more varied ▪ No BH/ SUD diagnoses ▪ 70% of MVPs, about half of overall visits

https://greatplainsqin.org/wp-content/uploads/2023/12/State-MVP-ND-Bene-Level-by-State-Report-FINAL_GPQIN-Website-2023_12_12.pdf

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MVP Group 1 – Care Coordination needs

Average age 55 years

69% Dual eligible (Medicare and Medicaid)

Extremely high utilization

Behavioral Health and/or Substance Use Disorder diagnoses

- What SDOH factor(s) could be at play?
- How can we provide support services that might decrease their need for ED visit?
  - MAT
  - BH services
  - Peer support
  - Outreach/follow up
  - Staffing considerations

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MVP Group 2 – Care Coordination Needs

Average age is 69 years

13 visits or less per rolling year

Characteristics are more varied

No Behavioral Health or Substance Use Disorder diagnoses

- What SDOH factor(s) could be at play ?
- How can we provide support services that might decrease their need for ED visit?
  - Chronic care management
  - Education
  - Meals on wheels
  - Medication
  - Transportation

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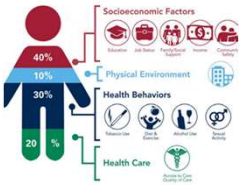
Mitigate the Underlying Driver of Utilization

What is the root cause for the need for frequent visits?

- Socioeconomic
- Food insecurity
- Housing instability
- Stress
- Transportation issue
- Lack of social connections
- Intimate partner violence
- Physical inactivity
- Substance use
- Mental health



Social Drivers of Health Initiative - NACHC

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Assess Your Patient Population

- CDC, Census, NDDHHS reports
- Community health needs assessments
- Review your facility-specific data
  - Utilization/diagnoses reports
  - SDOH assessments

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The MVP Method

1. Identify & Prioritize
2. Engage
3. Develop & Document
4. Implement & Coordinate
5. Monitor & Evaluate

INSTITUTE_BRIEF_CHS_MVP_METHOD_0423.pdf (advancinghealthvalue.org)

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Elements of the MVP Method

- Threshold approach
- Determine the underlying driver of utilization
- Address or mitigate the underlying driver of utilization

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Interventions and Tools

- Care Coordination
- Community Health Worker – "CHW"
- Health Literacy
- Teach-back
- Age-Friendly 4Ms Principles
  - What Matters, Medication, Mentation, Mobility
- Sepsis protocols in NH for early identification

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Best Practices

- SDOH assessments and follow up action
- Transition care process, follow-up calls to high-risk patients discharged from Inpatient & ED
- Pharmacy reviews med list and uses teach-back
- Have monthly interdisciplinary meeting to review MVP and problem-solving
- Help patients make follow-up appts, confirm contact info
- Consider behavioral health needs equal to physical health needs

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Community Collaboration Opportunities

- Home health/respite care/homemaker services
- Community paramedic
- Community health systems
- Local organizations
  - Global Neighbors
  - Support groups
  - Aging in Community groups
- Social Media
- Food banks/food pantries
- Transportation assistance
- Public health
- Library
- Medication Assisted Treatment (MAT)

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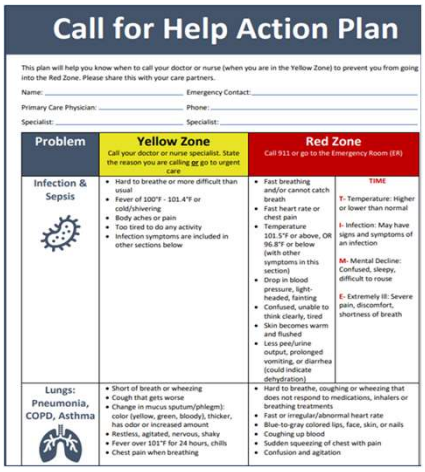
When to Call for Help Tool



Call for Help Action Plan

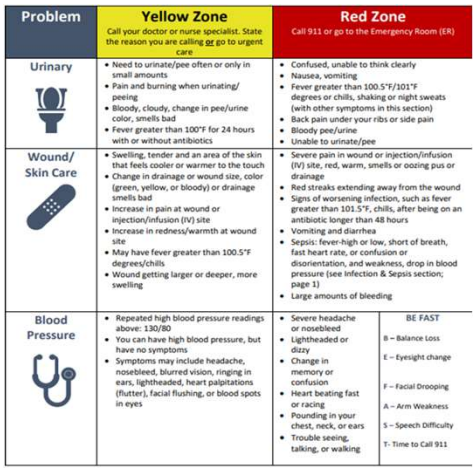
This plan will help you know when to call your doctor or nurse (when you are in the Yellow Zone) to prevent you from going into the Red Zone. Please share this with your care partners.

Name: _____ Emergency Contact: _____

Primary Care Physician: _____ Phone: _____

Specialist: _____ Specialist: _____

Problem	Yellow Zone Call your doctor or nurse specialist. State the reason you are calling or go to urgent care	Red Zone Call 911 or go to the Emergency Room (ER)	
Infection & Sepsis	• Hard to breathe or more difficult than usual • Fever of 100°F - 101.4°F or cold/shivering • Body aches or pain • Too tired to do any activity • Infection symptoms are included in other sections below	• Fast breathing and/or cannot catch breath • Fast heart rate or chest pain • Temperature 101.5°F or above, OR 96.8°F or below (with other symptoms in this section) • Drop in blood pressure, light-headed, fainting • Confused, unable to think clearly, tired • Skin becomes warm and flushed • Less pee/urine output, prolonged vomiting, or diarrhea (could indicate dehydration)	TIME T- Temperature: Higher or lower than normal I- Infection: May have signs and symptoms of an infection M- Mental Decline: Confused, sleepy, difficult to rouse E- Extremely Ill: Severe pain, discomfort, shortness of breath
Lungs: Pneumonia, COPD, Asthma	• Short of breath or wheezing • Cough that gets worse • Change in mucus sputum/phlegm): color (yellow, green, bloody), thicker, has odor or increased amount • Restless, agitated, nervous, shaky • Fever over 101°F for 24 hours, chills • Chest pain when breathing	• Hard to breathe, coughing or wheezing that does not respond to medications, inhalers or breathing treatments • Fast or irregular/abnormal heart rate • Blue-to-gray colored lips, face, skin, or nails • Coughing up blood • Sudden squeezing of chest with pain • Confusion and agitation	



Problem	Yellow Zone Call your doctor or nurse specialist. State the reason you are calling or go to urgent care	Red Zone Call 911 or go to the Emergency Room (ER)	
Urinary	• Need to urinate/pee often or only in small amounts • Pain and burning when urinating/peeing • Bloody, cloudy, change in pee/urine color, smells bad • Fever greater than 100°F for 24 hours with or without antibiotics	• Confused, unable to think clearly • Nausea, vomiting • Fever greater than 100.5°F/101°F degrees or chills, shaking or night sweats (with other symptoms in this section) • Back pain under your ribs or side pain • Bloody pee/urine • Unable to urinate/pee	
Wound/ Skin Care	• Swelling, tender and an area of the skin that feels cooler or warmer to the touch • Change in drainage or wound size, color (green, yellow, or bloody) or drainage smells bad • Increase in pain at wound or injection/infusion (IV) site • Increase in redness/warmth at wound site • May have fever greater than 100.5°F degrees/chills • Wound getting larger or deeper, more swelling	• Severe pain in wound or injection/infusion (IV) site, red, warm, smells or oozing pus or drainage • Red streaks extending away from the wound • Signs of worsening infection, such as fever greater than 101.5°F, chills, after being on an antibiotic longer than 48 hours • Vomiting and diarrhea • Sepsis: fever-high or low, short of breath, fast heart rate, or confusion or disorientation, and weakness, drop in blood pressure (see Infection & Sepsis section; page 1) • Large amounts of bleeding	
Blood Pressure	• Repeated high blood pressure readings above: 130/80 • You can have high blood pressure, but have no symptoms • Symptoms may include headache, nosebleed, blurred vision, ringing in ears, lightheaded, heart palpitations (flutter), facial flushing, or blood spots in eyes	• Severe headache or nosebleed • Lightheaded or dizzy • Change in memory or confusion • Heart beating fast or racing • Pounding in your chest, neck, or ears • Trouble seeing, talking, or walking	BE FAST B – Balance Loss E – Eyesight change F – Facial Drooping A – Arm Weakness S – Speech Difficulty T- Time to Call 911

https://greatplainsqin.org/wp-content/uploads/2023/04/When-to-Call-for-Help-Tool-FINAL-FINAL-APRIL-2023.pdf

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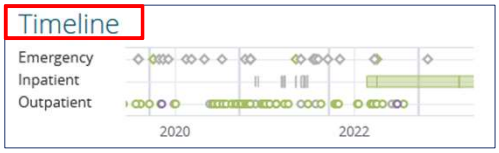
Tools & Resources to Decrease ED Utilization

NORTH Dakota | Health Information Network
Be Legendary.™ INFORMATION TECHNOLOGY

Encounter History

Admission	Discharge	Admit Reason	Visit Type	Specialty	Facility
Mar-10-2023	Mar-10-2023	testing fax	Preadmit	Radiology	Trinity Hospital
Mar-03-2023	Mar-03-2023		Inpatient	MED	Presentation Medical Center
Oct-26-2022	Oct-26-2022		Emergency	ED	St. Andrews Health Center - Emergency Room
Aug-18-2022	Aug-18-2022	TEST	Preadmit	Radiology	Trinity Hospital
Jul-20-2022	-		Outpatient	Unclassified	CHI St. Alexius



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Better Together

"Most companies want to come into healthcare and "disrupt" when really what they need to come in and do is radically collaborate. Too many companies draw a picture of the healthcare system with themselves at the center and everybody else revolving around them. If you did it the right way and if the person actually was in the center of their healthcare needs, we would build a support structure, common goals, and resources around them.

People should be the reason we use to get out of our silos."

- Andy Slavitt
President's Council of Advisors on Science and Technology (PCAST)

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Questions?

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GPQIN Resources

- Care Coordination Tools and Resources
- Care Coordination - Caring for the Complex Patient: *A Behavioral Health Perspective*
- Webinar Series: Ensuring Medication for Opioid Use Disorder (MOUD) Treatment through the Care Continuum

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Resources

- National CLAS Standards
- Building An Effective Care Pathway for Multi-Visit Patients
- The "High Utilizers": Transforming Care for Multi-Visit Patients (MVPs) with Dr. Amy Boutwell
- A Revolutionary Approach to Improving Health Care Delivery
- Collaborative Healthcare Strategies: Transform Care Delivery
- Institute for Advancing Health Value
- Lower anticoagulant dose means less bleeding in older residents with NVAF, study finds - Clinical Daily News - McKnight's Long-Term Care News

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Resources

- Emergency Department Utilization - NCQA
- Appropriate ED Utilization Leading to Better Care Coordination (ajmc.com)
- Improving Care Coordination and Reducing ED Utilization Through Patient Navigation (ajmc.com)
- Understanding Why ER Utilization Must Be a Priority (iheruc.com)
- Health, United States 2020–2021 (cdc.gov)

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North Dakota Team

Carrie Sorenson, PharmD
Heather Wilson, LCSW
Lisa Thorp, BSN, RN

Contact Us: firstname.lastname@greatplainsqin.org

Thank You!

greatplainsqin.org | 800/458-4262

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