1220 S. Wood Street
Chicago, IL 60608

April 30, 2018

Illinois community Health Foundation
Attention: Board of Directors
500 S. Ninth St.
Springfield, IL 62701

Mile Square Health Center
Population Health Management Program

Final Report to the Illinois Community Health Foundation (ICHF)

I. Project Description

This project aimed to build the infrastructure necessary to implement a sustainable population health management program to optimize patient care throughout our Mile Square Health Center enterprise. A key component of the program is data-driven clinical decision making through the use of health information technology to improve quality and clinical outcomes of our patients. For this purpose, we began utilizing Forward Health Group's software and customized web-based platform, Population Manager, to extract, map, analyze and report patient-physician-level data; with a particular focus on two chronic disease measures: Diabetes and Hypertension. To shore up and strengthen the program's infrastructure, we needed informatics and data support. With grant support from the Illinois Community Health Foundation (ICHF), we were able to obtain much-needed support by way of consulting services through the UI Health IT Department over the course of the funded project. These services included data extraction from our Cerner EHR, data management and analysis. As a result, we have made considerable strides toward strengthening our Population Health Management Program and are already seeing improvements in quality and clinical outcomes of our patients. Project outcomes to date, use of funds, objective measures and grant expenditures related to the project are further described below.

II. Successful Outcomes

Mile Square's Forward Health population health manager tool has allowed us to extract and analyze data on a number of quality measures; but we have prioritized two key measures that have impacted large numbers of our patients: Diabetes and Hypertension. With support from ICHF, we have achieved measureable success on our Diabetes measure in a relatively short

period of time; while we are still aiming to achieve our target for Hypertension by 2019. Below, we discuss successes and challenges related to each of these measures.

Diabetes: We have been successful in implementing our population health management software, which has allowed us to meet our target goals for diabetes: 75% of diabetic patients with A1c levels of less than 9 percent (A1c<9), ahead of our 2019 target. Once we were able to mine our EHR for population data for targets set forth by our quality team, we assembled our care coordination team to review registries created by the software program. Having Information Services informatics and data support, using the software program, allowed us to create registries and allow our Quality Care team to review high-risk patients and perform outreach to ensure that our patients have the correct intervention. We are proud that we have already met our target goal for Diabetes well ahead of schedule. Ongoing use of the population health management software will enable us to sustain this progress.

Hypertension: We continue to work toward achieving our goal of increasing the percentage of adult patients with diagnosed hypertension of less than 140/90 to 75% by 2019.

III. Use of funds

Foundation funds were utilized to support development of Mile Square's population health management infrastructure, including health informatics consulting services to oversee data management, analyze data for patient quality and process improvements, and train and advise other staff on use of population health management software. With the assistance of informatics services and data support, we have been able to improve data extracts between our EHR and the Forward Health platform. Overall, this has allowed us to use "real-time" data to drive our quality and allow providers and our care coordinators to proactively respond to and timely address the needs of our chronically-ill, high-risk patients, thereby enhancing the patient experience and improving outcomes.

In addition, we were able to utilize data and information from the Forward Health platform to assist us in our application for Patient Centered Medical Home (PCMH) status Level 3 through the National Committee for Quality Assurance in 2017. We utilized data reports (diabetes, asthma, immunizations and hypertension) generated from Forward Health to complete various phases of PCMH. While we successfully passed Phase 1 of the PCMH Corporate Tool, we did not achieve PCMH designation. We plan to continue to use the Forward Health population health management tool to further our goal of obtaining PCHM Level 3 status. Of note, we were successful in deploying our population health management software tool for data extraction in our most recent quality audit to achieve Medical Home Program certification with one of our insurance plans.

IV. Objective Measures

As mentioned, this project focused on two objective measures for quality improvement: 1) increasing the percentage of adult diabetic patients whose Hemoglobin A1c (HbA1c) is less than 9 percent – from 57% to 75%; and 2) increasing the percentage of adult patients with diagnosed hypertension of less than 140/90 – from 57% to 75%. As of April 27, 2018, we reached our goal (75%) for Diabetes well ahead of our 2019 target year. Our Hypertension measure declined slightly – from 57% to 54%. Hypertension remains a priority; and we intend to dedicate more resources to improve patient outcomes on this quality measure by our 2019 target.

QUALITY OF CARE MEASURE	CURRENT (04/27/2018)	OBJECTIVE/TARGET 2019
Diabetes, A1c <9%	75%	75%
Hypertension, <140/90	54%	75%

As we have experienced both the successes and challenges of population health management using our software, we have now built in registries to address any of the many metrics for HRSA UDS, HEDIS and Medicare STARS to improve the quality and health of our patient population.

We continue to provide a strong focus on all quality measures, allocating monthly targets for quality so that we may address several target goals in any given year. This allows us to allocate resources as needed.

Our patients have benefited the most from targeted quality care and coordination. We utilize our population health software with Information Technology/Information Services support to focus on patients who have multiple co-morbidities and may be present on multiple chronic medical condition registries.

We plan to utilize our successes without population health management software and Quality Care team to achieve Patient Centered Medical Home Level 3 status when applications open this fall.

V. Expenditure of grant funds related to the project

We used grant funds to purchase health informatics services. To do so, we established an agreement with the University of Illinois IT Department to purchase consultant services for data extraction from our Cerner EHR, data management, and data analysis, totaling approximately 520 hours for a cost of $50,837. Of this amount, ICHF grant funds accounted for $20,000. Mile Square contributed $30,837 in salary and associated benefits.