From Transaction to Total Value Care

Geisinger's Transformation Roadmap

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Agenda

- Put yourself in your patient's shoes
- The Geisinger Story
  - History
- The Geisinger Transformation
  - Integrated Population Management
  - Value Micro-Delivery Systems
  - Quality Outcomes Program
- Guide to using data

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Our Founder

"Make my hospital right, make it the best."

Abigail Geisinger
1827-1921

"Geisinger Quality – Striving for Perfection"… 2006 - 2011

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Geisinger Health System

WESTERN HUB
CENTRAL HUB
NORTHEASTERN HUB

Lewisburg
Milton
Knapper
Lycoming
Millville
Bloomsburg General Surg
Reichart Road
Berwick
Tunkhannock
Intermountain Medical Group
Dallas
Nicholson
Dallas
Kingston
Wyoming
Pittston
Moosic
Lake Scranton
Geisinger Specialty Clinic-WB
Intermountain Medical Group
Mundy
Mountainhome
Mt Pocono
Kistler
Mountaintop
Hazleton
Mahanoy City
Orwigsburg
Frackville
Pottsville
Catawissa
Kulpmont
Shamokin Specialty Care
Sunbury
Selinsgrove Specialty Clinic
Juniata
Selinsgrove
Family Practice Center
Selinsgrove
Family Practice Center
Mifflinburg
Lewistown
Scenery Park
University Drive
Gray's Woods
Philipsburg
Bellefonte
Lock Haven

Marworth
Geisinger South Wilkes-Barre
Woodbine
Geisinger Wyoming Valley
Geisinger Medical Center
Gray's Woods

Erie, Warren, McKean, Potter, Tioga, Bradford, Susquehanna, Wayne, Wyoming, Sullivan, Lackawanna, Pike, Crawford, Forest, Venango, Mercer, Clarion, Cameron, Elk, Lycoming, Clinton, Columbia, Lawrence, Butler, Jefferson, Centre, Union, Montour, Monroe, Carbon, Clearfield, Armstrong, Beaver, Indiana, Snyder, Northumberland, Schuylkill, Northampton, Lehigh, Mifflin, Juniata, Cambria, Blair, Allegheny, Westmoreland, Huntingdon, Perry, Dauphin, Lebanon, Berks, Bucks, Washington, Montgomery, Cumberland, Somerset, Bedford, Franklin, Lancaster, York, Fulton, Fayette, Greene, Adams, Chester, Philadelphia, Delaware

Last updated 11/12/09

- Geisinger ProvenHealth Navigator Sites
- Contracted ProvenHealth Navigator Sites
- Geisinger Medical Groups
- Geisinger Specialty Clinics
- Geisinger Inpatient Facilities
- Ambulatory Care Facility
- Geisinger Health System Hub and Spoke Market Area
- Geisinger Health Plan Service Area
- Careworks Convenient Healthcare
- Non-Geisinger Physicians With EHR

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Geisinger Health System

An Integrated Health Service Organization

Provider Facilities
$1,671M

Physician Practice Group
$757M

Managed Care Companies
$1,541M

- **Geisinger Medical Center**
  - ***Danville*** *– includes Hospital for Advanced Medicine, Janet Weis Children's Hospital, Women's Health Pavilion, Level I Trauma Center, Ambulatory Surgery Center*
  - ***Geisinger Shamokin Community Hospital***
- **Geisinger Northeast**
  - ***Geisinger Wyoming Valley Medical Center***
    includes Heart Hospital, Henry Cancer Center,
    and Level II Trauma Center
  - ***Geisinger South Wilkes-Barre*** *includes Adult and Pediatric Urgent Care, Ambulatory*
    Surgery Center, Inpatient Rehabilitation, Pain Management, and Sleep Center.
  - ***Geisinger Community Medical Center***
- **Geisinger-Bloomsburg Hospital**
- **Marworth Alcohol & Chemical Dependency Treatment Center**
- **Mountain View Care Center**
- **Bloomsburg Health Care Center**
- **> 77K admissions/OBS & SORUs**
- **1,619 licensed inpatient beds**

- **Multispecialty group**
- **~950 physician FTEs**
- **~560 advanced practitioners FTEs**
- **71 primary & specialty clinic sites (41 community practice sites)**
- **1 outpatient surgery center**
- **~ 2.3 million clinic outpatient visits**
- **~380 resident & fellow FTEs**

- **~322,000 members (including ~68,000 Medicare Advantage members)**
- **Diversified products**
- **~34,000 contracted providers/facilities**
- **43 PA counties**

Note: Numerical references based on fiscal 2013 budget.

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The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

The Quality of Health Care Delivered to Adults in the United States

Elizabeth A. McGlynn, Ph.D., Steven M. Asch, M.D., M.P.H., John Adams, Ph.D., Joan Keesey, B.A., Jennifer Hicks, M.P.H., Ph.D., Alison DeCristofaro, M.P.H., and Eve A. Kerr, M.D., M.P.H.

Adults in the US received 54.9% of recommended care

Acute care – 53.5%

Care for chronic conditions – 56.1%

Preventive care – 54.9%

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Time Required for Primary Care of Patients

• Acute Care	4.6 hours/day
• Preventive Care	7.4 hours/day
• Chronic Care	10.6 hours/day
	22.6 Hours/day

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PHN: The foundation for transformation

- Transform primary care from transaction to value focus
- Act as Value Vehicle (Integrator) to improve quality and efficiency across the spectrum of care

Control Cost

Quality

Enhance Experience

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Coordination Across Care Settings Provides
360 degree patient care and navigation
AMBULANCE ENTRANCE
EXIT

Components of Transformation

Geisinger's PHN model five core components:

- ***Patient Centered Primary Care***
- ***Integrated Population Management***
- ***Value Micro-Delivery Systems***
- ***Quality Outcomes Program***
- ***Value Reimbursement Program***

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Patient Centered Primary Care

- Patient and family engagement & activation
  - Self-management education
  - Informed decision making
- Physician-led team based care
  - See value of population management
  - Set stage for expectation of practice
  - Acute/chronic illness care with enhanced access for expanded scope of services
  - Responsibility and awareness of where patient is at all times – hospital, SNF, home
- Chronic disease and preventive care optimization via IT-enabled planned visits
  - EMR tools
  - HP tools for non-EMR practices

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Integrated Population Management

- Embedded Case Managers
  - Use of Predictive Modeling
- Monthly “Medical Home Meetings”
  - Physician leadership & engagement
  - Role delineation
  - Case studies
  - Outcomes review
- Data and Tools
  - Pushing typical HP analytics out to practice
  - Leveraging EHR capabilities

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Predictive Modeling

Site#	Forecasted Risk Index	AIS	CIS	Risk Rank	Sex	Age	Total Paid	Forecasted Cost	Primary ETG Group	Program Status as of 8/27/08
C101	4.1	91	35	**5**	M	82	$42,187.00	$44,456.00	Cerebrovascular Accident	MHOpen
C101	4	80	37	**5**	M	68	$46,972.00	$43,405.00	Cardiovascular Surgery	Closed-Need met
C101	6.21	100	28	**5**	M	67	$137,724.00	$67,387.00	Infectious Disease	MHIdentified
C101	3.19	93	25	**5**	F	75	$70,344.00	$34,563.00	Degenerative Ortho disease	MHCL-Needs meet
C101	4.53	94	60	**5**	M	81	$49,157.00	$49,173.00	Cerebrovascular Accident	
C101	10.2	97	51	**5**	F	71	$133,870.00	$110,630.00	Renal Failure, Chronic & Nephrosis	MHOpen
C101	5.59	90	62	**5**	M	81	$25,981.00	$60,613.00	Renal Failure, Chronic & Nephrosis	MHIdentified
C102	8.87	95	50	**5**	F	79	$113,895.00	$96,235.00	Renal Failure, Chronic & Nephrosis	MHCL- CC

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Embedded Case Management has been Core to our Success

Personal Care Link	Embedded Case Manager	Recognized Team Member
Comprehensive Care Review – medical, social support	- **High risk** patient caseload - 15 - 20% Medicare - 5% commercial - 125 - 150 pts per CM	Regular follow-up of high risk patients
TOC follow-up – acute care, SNF, ED	- 1 CM per 800 Medicare lives - 1 CM per 5000 commercial lives	Facilitates access – PCP, specialist, ancillary
Direct phone access – questions, exacerbation protocols	- Not disease management focused - Focus on those at most risk - Focus on driving issue within the case	Facilitate special arrangements – home care, hospice, AAA
Patient, family support contact		Links health care team to payer

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Medical Home Meetings

- Workflow issues
  - Reinforce communication
  - Identify opportunities
  - Propose solutions
- Case study review
  - Hospitalizations and readmissions
  - "Successes in the Office"
- Metrics review

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Medical Home Meetings Transitions of Care

- Patient contact within 24-48 hours post discharge
- Telephonic outreach
  - Medication reconciliation
  - Ensure safe transition post discharge with appropriate services in place
    - Home Health
    - DME
    - Safe to be in their home?
  - Facilitate post-hospital PCP appt. within 3 - 5 days

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Medical Home Admission Review

Was the patient in Active CM prior to admission?

When/What was the first contact with the office?

Did we employ any home management strategies?

Did we employ any office based strategies?

Did we employ any advanced office based strategies (IM/TV/Home IV etc)?

Did we make appropriate post admit CM contact (ideally <24 hours, target <=48 hours)?
Did we make appropriate post admit provider contact (ideally 3-5 days, target <=7 days)?

How could have we responded differently?

How was the process from the patient perspective?

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ProvenHealth Navigator Quality Criteria - 2009

Quality Indicator	Goal
Patient Encounters	**Annual increase patient encounters**
Diabetes	**Annual Improvement site Diabetes Bundle**
Coronary Artery Disease	**Annual Improvement site CAD bundle**
Preventive Care	**Annual Improvement site Preventive bundle**
Heart Failure	**$\geq$ 90% patients w/documented action plan**
Follow-up with Provider	**$\geq$ 75% within 1 week of Inpt/SNF discharge**
Follow-up with CM	**$\geq$ 75% telephone contact w/in 24 - 48 hrs discharge**
Patient Satisfaction	**PHN patient satisfaction survey implemented on Phase 1 and Phase 2 sites**
Nursing Home Management	**Nursing Home Medical Management Model operational and serving at least 2 MH sites per region**
NCQA PPC-PCMH Certification	**Certification obtained**

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ProvenHealth Navigator Quality Criteria - 2010

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Follow-up with CM	**$\geq$ 75% telephone contact w/in 24 - 48 hrs discharge**
Patient Satisfaction	**PHN patient satisfaction survey**
Nursing Home readmissions	**Educate providers on the NH readmission tool/ each site to be aware of their current NH readmission rates**
Efficient Specialist	**Develop plan to utilize efficient specialists**
Quality Improvement project	**Develop a site-specific QI project**

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2011 Quality Indicators

Quality Indicators	Weight
Diabetes Bundle: - Demonstrate improvement in bundle score over prior year or maintain an overall bundle rate above defined threshold and demonstrate improvement in one control measure such as A1C <7% (< 8% for GOLD), LDL <100, or BP<130/80 over prior year or maintenance above CPSL's optimum achievement level	10%
CAD Bundle: - Demonstrate improvement in bundle score over prior year or maintain an overall bundle score above defined threshold and demonstrate improvement in one control measure such as LDL<100, or <70 if high risk, or BP<140/90 over prior year or maintenance above CPSL's optimum achievement level	10%
Preventive Care Bundle: - Demonstrate improvement in bundle score over prior year or maintain an overall bundle rate above defined threshold and demonstrate improvement in Mammogram screening, Pap Screening, or Colon cancer screening over prior year or maintenance above CPSL's optimum achievement level	10%
Provider follow-up: ≥ 75% provider visit within 7 days of acute or SNF discharge	10%
HTN Bundle: - Develop and implement a process to improve htn control with demonstrated improvement in blood pressure control from baseline	10%
CM follow-up: ≥ 75% telephone contact within 48 hrs of acute or SNF discharge	10%
Advanced Illness: - Develop & implement a training program on advanced illness for staff AND develop a reporting tool for measuring documentation of Advance Directives	10%
Nursing Home Readmission Rate: - Demonstrate improvement over previous year or maintain a rate below the defined threshold in the "Nursing Home to home" 30 day-readmission rate	10%
PHN Patient Satisfaction: - Review site specific patient satisfaction data & implement action plan that was developed in 2010	10%
Quality Improvement Project: - Implement the 2010 QI project developed & demonstrate an improvement from baseline	10%
TOTAL	**100%**

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EHR Alert for Scheduling

Make Appt | Walk In | Quick Appt | Pt Wait List | Pt Hx Report | Itinerary | Locate Pt | Wk @ Glance | Reg | Ins Scans

Patient Warning(s)

+ Patient Admitted Warning
+ Patient Address Update Required
+ Patient Dismissed Warning
+ Patient Dismissed Exceptions
+ Medical Home Patient: Active Case Management

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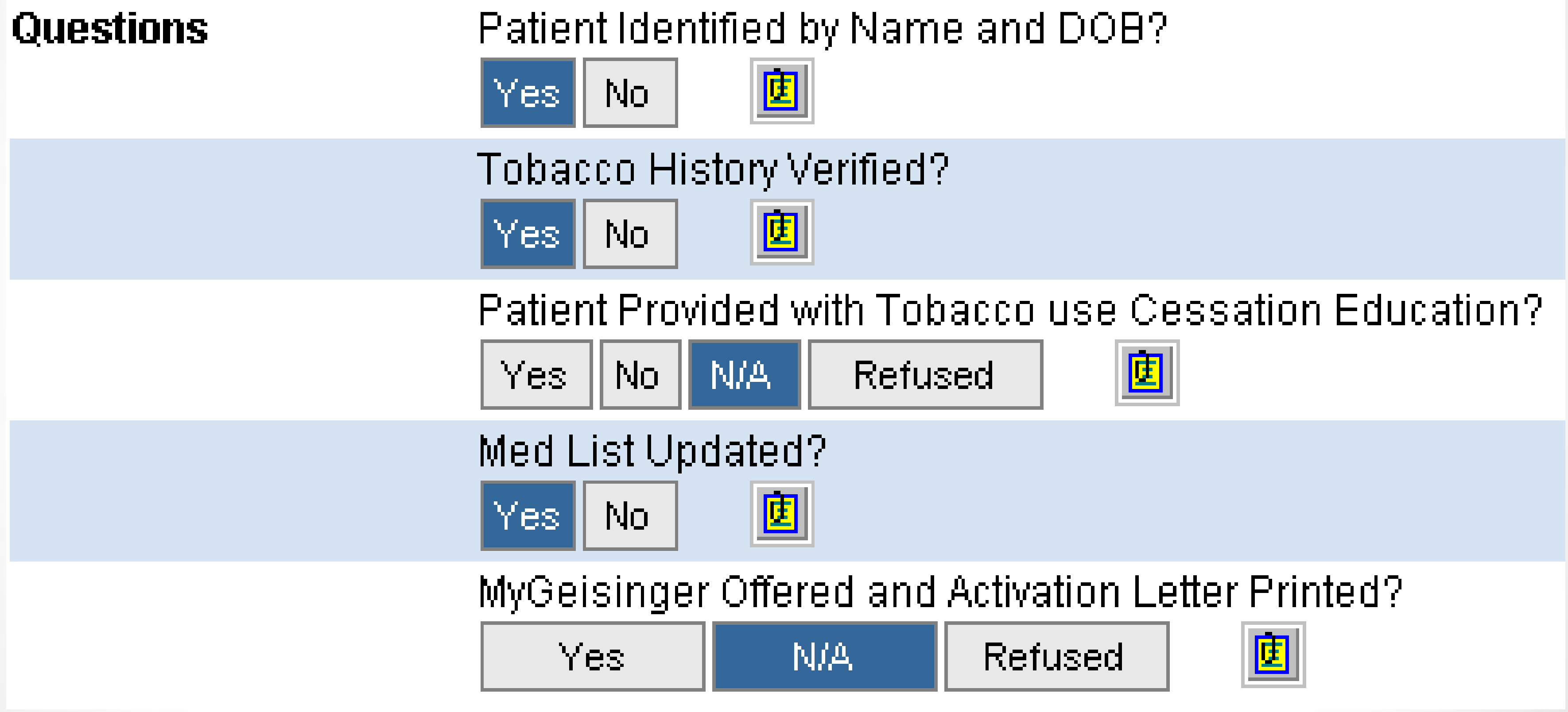
Nurse Rooming Tool



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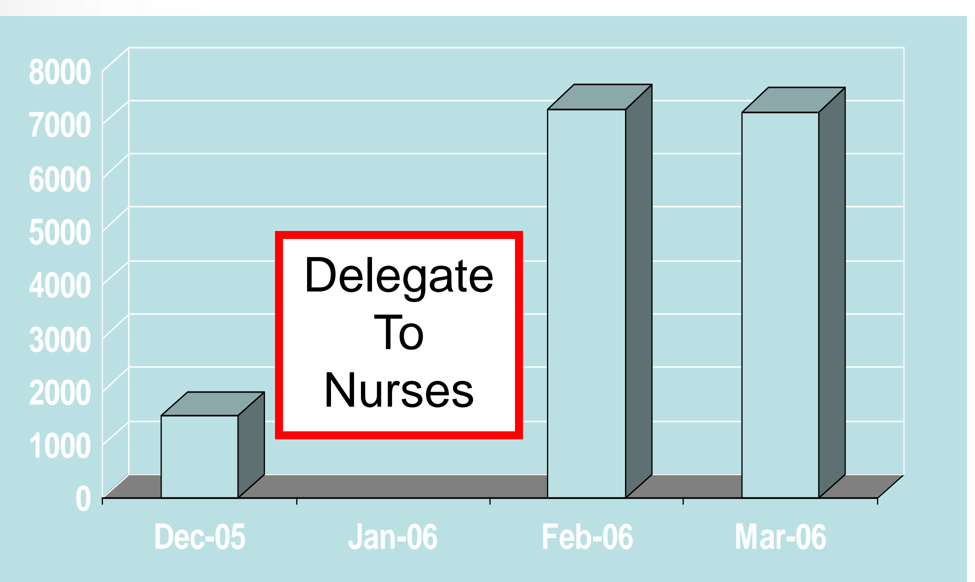
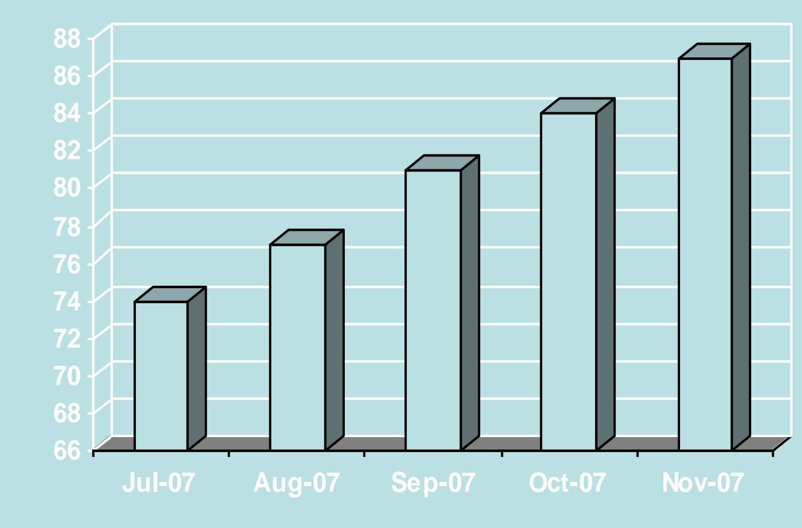
REDEFINING BOUNDARIES®

Nurse Rooming Tool Improvements

MyG Enrollments



Urine Micro albumin



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GEISINGER
REDEFINING BOUNDARIES

Patient Activation: Portal-Based Report Card

Your online health management tool

The following Health Reminders are recommended for people of your age, gender, and medical history. **If the procedures and dates are different from what your doctor has discussed with you, please follow your doctor's recommendation.**

If you want to find previous dates that health reminders were completed, click date Last Done.

Schedule	Name	Due Date	Status	Last Done
☐	DILATED EYE EXAM (PERFORMED BY AN EYE DOCTOR)	03/06/1968	Overdue	
☐	URINE MICROALBUMIN (URINE PROTEIN)	03/06/1968	Overdue	
☐	DIABETIC FOOT EXAM (AT LEAST EVERY 12 MONTHS)	03/06/1968	Overdue	
☐	PNEUMONIA SHOT (ONCE IN A LIFETIME, MINIMUM)	03/06/1968	Overdue	
☐	HEMOGLOBIN A1C (3 MONTH BLOOD SUGAR AVERAGE)	03/06/1968	Overdue	
	Mammogram-yearly, Ages 40-75	07/07/2006		07/07/2005
	DILATED EYE EXAM (PERFORMED BY AN EYE DOCTOR)	10/01/2006		
	LDL CHOLESTEROL (BAD CHOLESTEROL)	01/28/2007		01/28/2006
	Pap Smear (Every 2 Years)	02/13/2008		02/13/2006

To request an appointment for one of the procedures listed above, check in the schedule column and click **Schedule**.

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Provider Best Practice Alerts

BestPractice Alerts

CKD-3. Hgb target 10-12.
Last HGB=8.8 on 7/31/2009
☑ Open SmartSet: GHS CKD STAGE 3 ABNORMAL HGB
Jump to CKD Management Report

CKD-3. Phosphorus target 2.7-4.6
Last PHOSPHORUS=5.2 on 7/31/2009
☑ Open SmartSet: GHS CKD STAGE 3 ABNORMAL PHOSPHORUS
Jump to CKD Management Report

Dx of CAD and comorbid condition(s) - DM, HTN, CKD, and/or LVSD. Consider ACE/ARB therapy.
Jump to Order Entry

Dx of CAD- LDL less than 100 is standard.
Last LDLCALC=165 on 7/31/2009
Last LDLDIRECT: Not on file
Last LDLCHOL: Not on file
☑ Open SmartSet: BPA GHS CAD LDL #3391

Hx of CAD. Consider aspirin, unless contraindicated.
☑ Open SmartSet: CAD ASPIRIN ORDER #3392

Dx of CAD and comorbid condition(s) - DM, HTN, CKD, and/or LVSD. Consider ACE/ARB therapy.
Jump to Order Entry

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Diabetes Best Practice Alerts

BestPractice Alerts

Action(s)

Dx of DM. LDL every 12 months, Standard <100.

☑ Open SmartSet: BPA GHS DIABETES LDL

Dx of DM. Pneumovax - at least one lifetime vaccine. One time revaccination >64 years old (if vaccine given more than 5 years ago).

☑ Open SmartSet: BPA_GHS_PNEUMOVAX

Dx of DM. Flu vaccine - once per flu season is standard.

☑ Open SmartSet: BPA-GHS_DIABETES_FLU

Dx of DM. HgbA1c every 3 months, Standard < 7%

Last HGBA1C: Not on file

☑ Open SmartSet: BPA - GHS DIABETES - HGBA1C Greater than 7.0

Dx of DM. Microalbumin every 12 month, Standard < 30.

☑ Open SmartSet: BPA GHS DIABETES MICROALBUMIN

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Diabetes: Patient Letter/Report Card

Last 2-3 values displayed

LDL values and goals.

Last BP readings

Personal Diabetic Report Card: Abigail L George

4/28/2006

Below is a summary of relevant Diabetes values that we feel could help you manage your health better. Feel free to discuss this with your care provider.

HEMOGLOBIN A1C

Your most recent Hemoglobin A1c values are:

HEMOGLOBIN, A1C(%)

Coll Dt/Tm	Resulted	Value	Status
3/2/06 11:23A	3/2/06	6.6*	FINAL
11/21/05 4:21P	11/22/05	8.7*	FINAL

The above values should be **LESS than 7 (< 7)**. If these are more than 7 then you have a higher chance of having eye, kidney, and heart problems in the future.

CHOLESTEROL

Your most recent LDL cholesterol (bad cholesterol) results are:

LDL (CALCULATED)(mg/dL)

Coll Dt/Tm	Resulted	Value	Status
11/15/05 8:20A	11/15/05	110	FINAL

The above values should be **LESS than 100 (<100).** If these are consistently higher than 100, then your chance for heart attack and stroke increases yearly.

BLOOD PRESSURE

Your most recent Blood Pressure readings are:

Last 3 BP Readings:

Date:	BP:
04/28/2006	100/60
04/25/2006	140/80
03/02/2006	124/80

The above values should be **LESS than 130/80**. Contact me if your readings at home are consistently higher than this.

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Chronic Care Management

Heart Failure

- Diuretic Titration Protocol
- Daily weights
- Tele-monitoring
- Education
- Self management
- Outreach

COPD

- Rescue kit
- Symptom monitoring
- Education
- Self management
- Medication
- Outreach

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DM Health Maintenance Alerts

Health Maintenance

Override | Cancel | Change HM Plan | Report

	Due Date	Procedure	Date Satisfied	Date Satisfied	Date Satisfied
➡	02/22/1978	DIABETES-PNEUMONIA VACCINE			
	11/28/2006	DIABETES-EYE EXAM	11/28/2005		
	11/14/2006	DIABETES-FLU VACCINE,YEARLY	11/14/2005		
	03/02/2007	DIABETES-FOOT EXAM	03/02/2006		
	09/02/2006	DIABETES-HGBA1C EVERY 6 MONTHS	03/02/2006	11/22/2005	02/23/1997
	11/15/2006	DIABETES-LDL EVERY 12 MONTHS	11/15/2005		
	11/28/2006	DIABETES-URINE MICROALBUMIN EVERY 12 M	11/28/2005		
	10/28/2006	MAMMOGRAM-YEARLY, AGES 40-75	10/28/2005-DONE E		
	11/21/2006	PAP SMEAR, YEARLY	11/21/2005		

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COPD Smart Set Tool

- ⊟ Rescue Antibiotics (multiple)
  - ☐ AUGMENTIN 875-125 MG TABS (10 days - start at onset of symptoms with your prednisone)
  - ☐ CEFTIN 500 MG TABS (10 days of therapy - start at onset of symptoms with your prednisone)
  - ☐ DOXYCYCLINE HYCLATE 100 MG CAPS (10 days of therapy - start at onset of symptoms with y
  - ☐ ZITHROMAX 250 MG TABS (5 days of therapy - start at onset of symptoms with your prednisone
- ⊟ Rescue Antibiotics - HISTORICAL MEDS (multiple)
  - ☐ HISTORICAL - AUGMENTIN 875-125 MG TABS (10 days - start at onset of symptoms with your p
  - ☐ HISTORICAL - CEFTIN 500 MG TABS (10 days of therapy - start at onset of symptoms with your
  - ☐ HISTORICAL - DOXYCYCLINE HYCLATE 100 MG CAPS (10 days of therapy - start at onset of sy
  - ☐ HISTORICAL - ZITHROMAX 250 MG TABS (5 days of therapy - start at onset of symptoms with y
- ⊟ Rescue Steroid (multiple)
  - ☑ PREDNISONE (PAK) 10 MG PO TABS (Taper Over 16 days start at the onset of symptoms with y
  - ☐ HISTORICAL - PREDNISONE (PAK) 10 MG PO TABS (Taper Over 16 days start at the onset of s

⊟ Patient Instructions - Go to Patient Handouts Activity (Tab)
- ⊟ Print from Patient Instructions Section - Allows to Print at Your Location (multiple)
  - ☑ COPD Rescue Patient Instructions (right click to make changes)

⊟ Chief Complaint/Reason for Call
- ⊟ Chief Complaint/Reason for Call (multiple)
  - ☑ Case Management - COPD Rescue Kit

⊟ Documentation
- ⊟ Notes (multiple)
  - ☑ COPD Documentation

⊟ Diagnosis

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DTP Smart Set Tool

- ⊟ Diuretic Titration Protocol
  - ⊟ Case Manager: DTP Documentation/Request to Provider (multiple)
    - ☐ Diuretic Titration Protocol: Patient with Once Daily Diuretic
    - ☐ Diuretic Titration Protocol: Patient with Twice per Day Diuretic
- ⊟ Medications
  - ⊟ DTP: Metolazone PRN (multiple)
    - ☑ METOLAZONE 2.5 MG PO TABS
    - ☐ HISTORICAL - METOLAZONE 2.5 MG PO TABS
- ⊟ Patient Instructions - Go to Pt Handouts Activitiy (Tab)
  - ⊟ Print from Patient Instructions Section - allows to print at your location (multiple)
    - ☑ Patient Instructions - Right click here to complete (F2)
- ⊟ Diagnosis
  - ⊟ Diagnosis (single)
    - ☑ CHF [428.0]
- ⊟ Chief Complaint
  - ⊟ Chief Complaint/Reason for Call (single)
    - ☑ Case Management - Diurectic Titration Protocol

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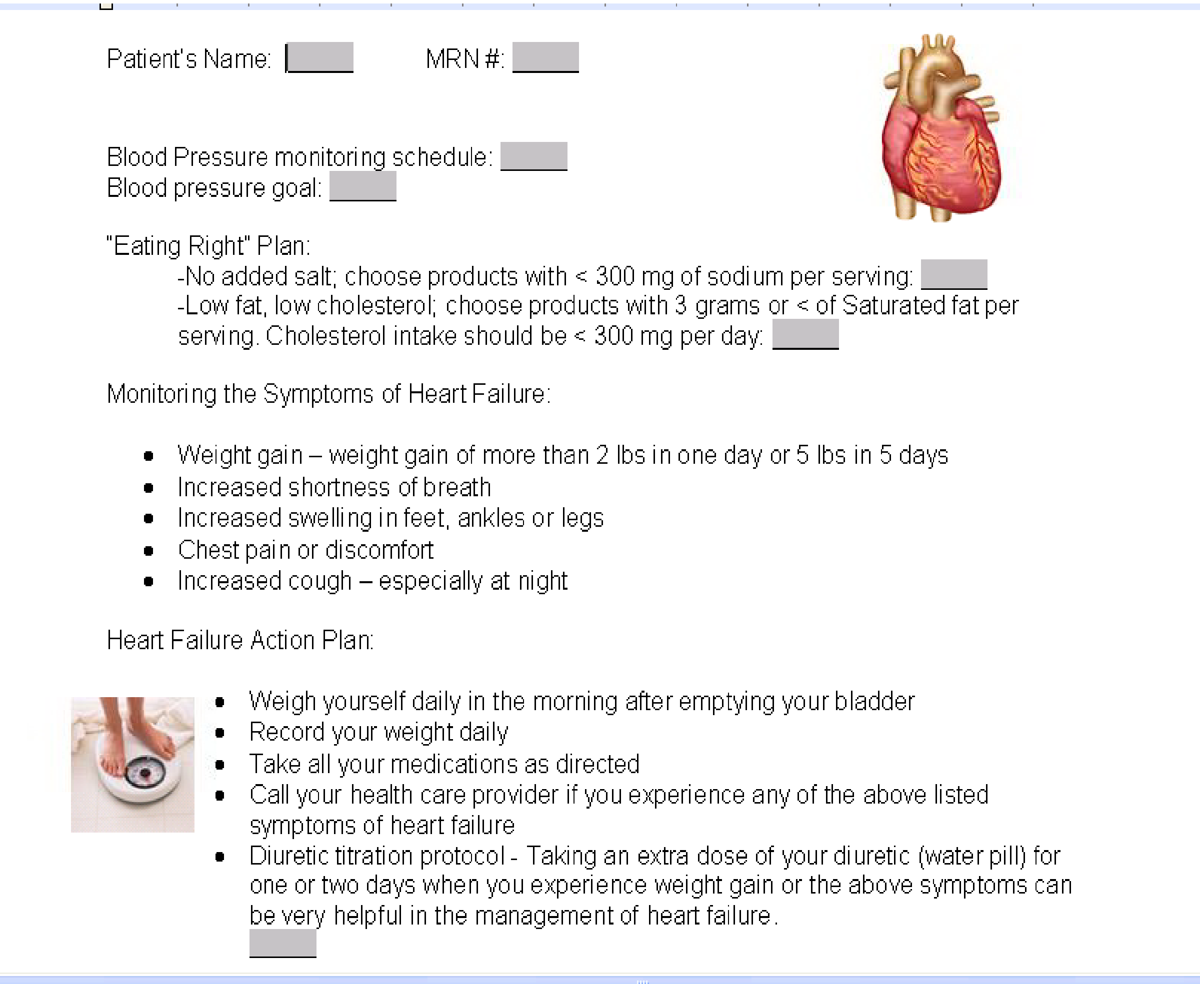
CHF Self Management Plan



Patient's Name: ____ MRN #: ____

Blood Pressure monitoring schedule: ____
Blood pressure goal: ____

"Eating Right" Plan:
-No added salt; choose products with < 300 mg of sodium per serving: ____
-Low fat, low cholesterol; choose products with 3 grams or < of Saturated fat per serving. Cholesterol intake should be < 300 mg per day: ____

Monitoring the Symptoms of Heart Failure:

- Weight gain – weight gain of more than 2 lbs in one day or 5 lbs in 5 days
- Increased shortness of breath
- Increased swelling in feet, ankles or legs
- Chest pain or discomfort
- Increased cough – especially at night

Heart Failure Action Plan:

- Weigh yourself daily in the morning after emptying your bladder
- Record your weight daily
- Take all your medications as directed
- Call your health care provider if you experience any of the above listed symptoms of heart failure
- Diuretic titration protocol - Taking an extra dose of your diuretic (water pill) for one or two days when you experience weight gain or the above symptoms can be very helpful in the management of heart failure.
____

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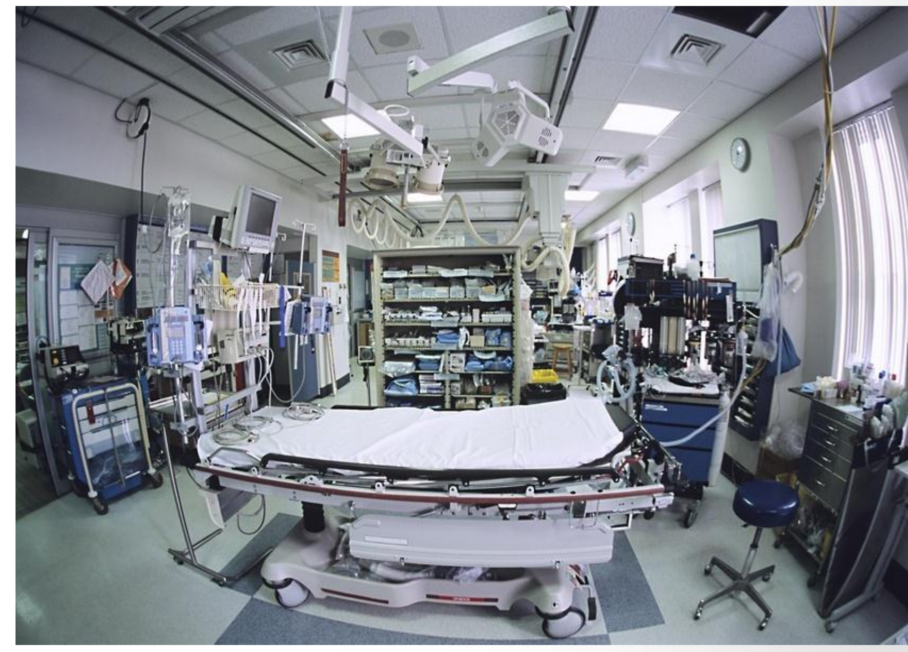
Value Care Systems

Collaboration of Partners:
Each Party Doing What It Does Best…

- 360 degree care systems
  - Specialty Care
  - Skilled Nursing Facilities
  - Home Health



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Collaboration of Partners:
Each Party Doing What It Does Best…

Primary Care	Specialty Care	Hospital	Health Plan
• Identify best practice • Design systems of care • Educate patient and family • Deliver care • Report patient outcomes • Continually improve	• Work with more complex patients • Disease-focused care • Guidance to POP for care plan if needed	• Stabilize patients • Assist with placement • TOC	• Population analysis • Align reimbursement • Finance care • Engage member and employer • Report population outcomes • Take to market

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Specialists Engagement

- CHF

  Cardiology input to develop – Diuretic Titration Pathway
- Osteoporosis

  HIROC

  Rheumatology to generate - dexa order when due

  PCP to signs pended order

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Specialists Engagement

- HTN
  - Pilot with Primary Care and Nephro for high touch HTN Management
- Diabetes
  - Pilot with Endocrinology
    - High touch
    - 12-week program
    - Based at PCP site with Certified Diabetic Educator
    - Direct contact with Endocrinology

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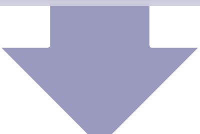
Linking Specialists to PHN

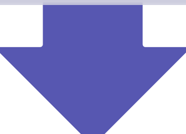
Active & Operational

RA, COPD, DM, HTN & Communication Patterns



Early Implementation

Hospitalists, Advanced Illness



Under Development

Peds Behavioral Health, Geriatrics, Liver Failure

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Collaboration of Partners:
Each Party Doing What It Does Best…

SNF Advanced Practitioner	Transitions Nurse	PCP
• Medication Reconciliation • Coordinate Care at SNF; ensure progress toward goal of discharge • Ensure follow-up with PCP at discharge with updated medications list and care plan • Resolve/treat acute issues that arise while in SNF	• Transition to home to SNF • Coordinate discharge to home or SNF with PCP/Home Health • Coordinate updated medications list to PCP/Pharmacy	• Optimize patient in Outpatient setting • Ensure follow-up after hospital or SNF stay

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Driving Innovation to Nursing Homes

- “SNFist” model in targeted nursing homes
  - Mid-level with daily presence in SNF
  - Close connectivity to PHN case manager

- Focus on transitions of care and length of stay
  - Hospital to SNF
  - SNF to home

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Opportunities for Innovation Exist in the Nursing Home

Current state of care in nursing homes:

- Skilled: 1 in 3 patients are readmitted back to acute care
- LTC: Average 2-4 hospital admissions annually
- Opportunities exist to improve quality – wounds, falls, infection, pain, etc.
- End of life poorly managed

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Creating a New Delivery Model is Critical

- Daily presence of an advanced practitioner
- Focus on care redesign
  - Medication reconciliation
  - Earlier identification of acute exacerbations
  - Prevention focus – good skin care, I's & O's, fall prevention
  - Enhanced connectivity to case manager & primary care team for discharge planning

Redesigning care in the Nursing Home as we have done in Primary Care

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SNFist Role

- See new admissions within 24 hours
- See skilled patients 2-3 times per week
- Communication with PHN Case Managers
- Communication with PCP
- See LTC patients every 30 days
- Utilize the health assessment tool

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SNFist Program Goals and Objectives

- **Transitions of Care from the SNF to Home**
  - Arrange a 7-day discharge f/u appointment with the PCP
    - Use Cadence schedule for GHS providers
  - Open Communication with Case Managers
    - Use EpicCare tools to alert the Case Manager prior to discharge
- **Improve Communication between Provider(s) and provide consistent follow-up care and routine care**
  - Use the Tools in EpicCare (Smart Sets)
    - Document the evaluations
    - Use Cadence tool to be able to track patients

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SNFist Program Goals and Objectives

- **The Advanced Practioner SNFist Model will improve the Transitions of Care; and therefore, will improve the *quality of care* given to our SNF patients**
- **Transitions of Care from the Hospital to the SNF**

  Goal: Decrease the readmission rate to below the National Average

  - Evaluate the patient within one working day of admission
  - Evaluate skilled patients biweekly per regulations
  - Evaluate LTC patients monthly per regulations
  - Evaluate and treat those patients that may have an acute need prior to their next visit
  - Perform a Health Risk Assessment (HRA) once annually if greater than a 30-day stay and within seven days upon admission

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Quality Outcomes Program

- Bundled Chronic Disease Metrics
  - Diabetes
  - Adult Prevention
  - Macrovascular
  - Microvascular

- Reductions in Inpatient and ED Usage

- Preventive Services Metrics
  - COPD
  - CHF

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Results have been very positive in all our phased rollouts*

Health status

- Diabetes bundle ↑
- Coronary disease bundle ↑
- Preventive care bundle ↑
- Readmissions ↓
- Admissions ↓

Member/Provider satisfaction ↑

Total Medical Cost ↓

*All results are measured across the entire population of patients, not just chronic disease patients

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Diabetes Bundle

Measures	Quality Standard
HgbA1C measurement	Every 6 months
HgbA1C control - Patient Specific Goal	< 7 or 7-8
LDL measurement	Yearly
LDL control - Patient Specific Goal	< 70 or < 100
Blood pressure control	< 130/80
Urine protein testing	Yearly
Influenza immunization	Yearly
Pneumococcal immunization	Once before 65, Once after 65
Smoking status	Non-smoker
Patients who receive/achieve ALL of the above	**DM Bundle Percentage**

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Diabetes Process Redesign

Automate

Computer/HER:
- **Alerts and Reminders As Pre-visit Planning**
- **Reminder letters – CareGaps Outreach**

Delegate

Clerical:
- **Scheduling of Flu/Pneumococcal, Follow-Up**

Clinic Nurse:
- **Immunizations, Lab Testing, Foot Exam**

Case Manager:
- **High-Intensity Coordination/Education**

Incorporate

Nurses:
- **Nurse Rooming Tool, Process Measure BPAs**

Providers:
- **Alerts and Reminders for Complex Decisions**

Activate

Patients and Families:
- **MyGeisinger, Patient Report Cards**

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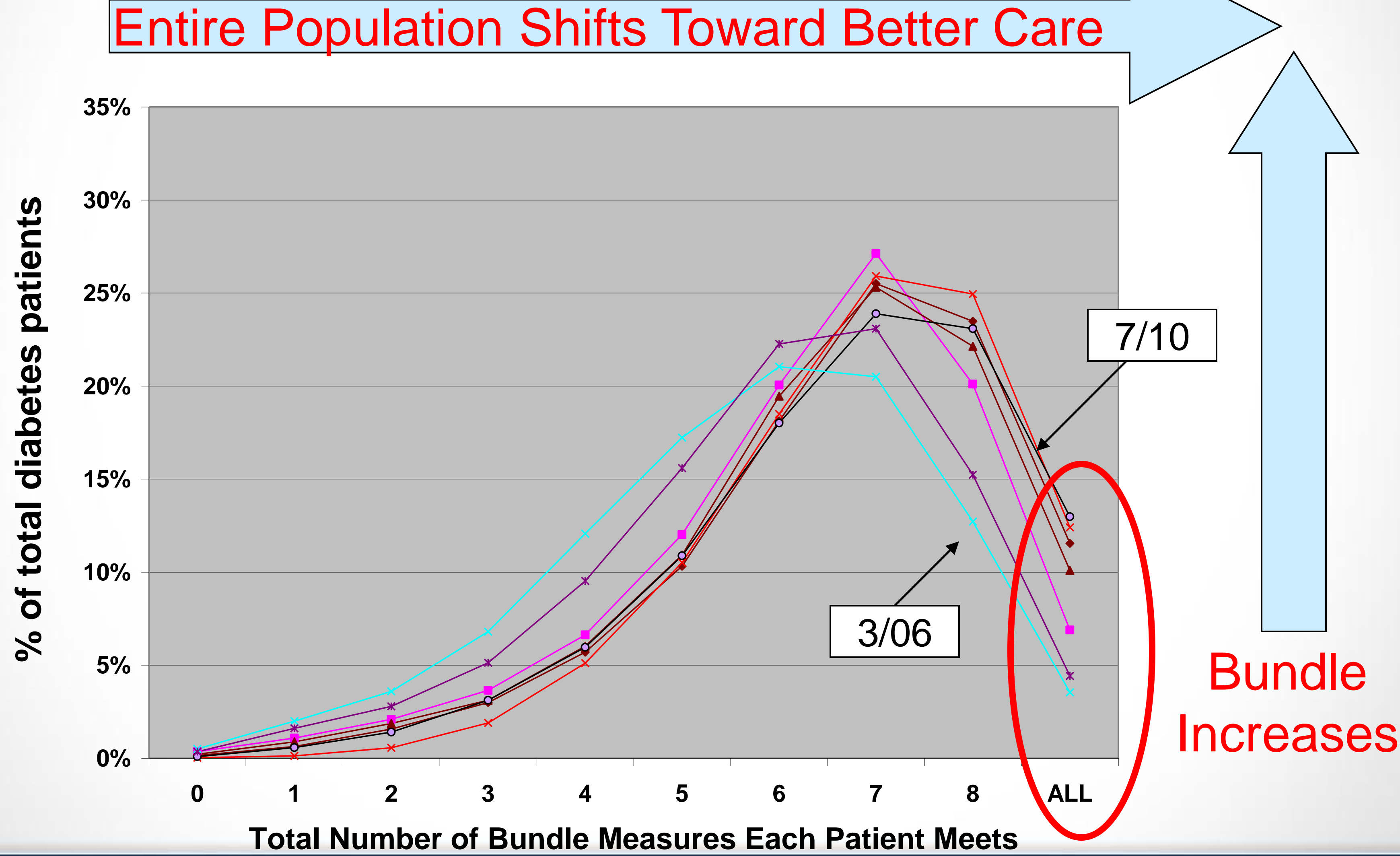
Diabetes Bundle Improvement



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Improving Diabetes Care for 24,749 Patients

	3/06	3/07	7/10	7/11
Diabetes Bundle Percentage	2.4%	7.2%	12.9%	12.5%
% Influenza Vaccination	57%	73%	75%	77%
% Pneumococcal Vaccination	59%	83%	84%	82%
% Micro albumin Result	58%	87%	78%	78%
% HgbA1c at Goal	33%	37%	52%	50%
% LDL at Goal	50%	52%	54%	55%
% BP < 130/80	39%	44%	54%	57%
% Documented Non-Smokers	74%	84%	85%	85%

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Adult Prevention Bundle

- Based on US Preventive Services Task Force (USPSTF) Recommendations and 2007 ACIP Immunization Schedule
- Received input from a broad group of primary care physicians from CPSL and GIM and also selected specialists
- Rollout 1/08
- 203,695 Patients
- 66% Of recommended tests performed on these patients
- Initial Adult Prevention Bundle Percentage = 9.2%

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Adult Prevention Bundle

	Recommendation	AGE/SEX						Adult Prevention Bundle
		18-49		50-64		Over 65		
		Female	Male	Female	Male	Female	Male	
Cancer Screening								
Breast Cancer	Mammogram every 2yr 40-49, every year 50-74	x (>40)		x		x (<75)		**x**
Cervical Cancer	Pap every 3 yr 21-64	x (>21)		x				**x**
Colon Cancer	Colonoscopy every 10 yrs or FOBT yearly			x	x	x (<85)	x (<85)	**x**
Prostate Cancer Discussion	Discuss prostate cancer screening yearly 50-74				x		x (<75)	**x**
Lung Cancer	Non-smoker	*See Tobacco Screening Below*						
Cardiovascular Disease								
Lipid Screening	Every 5 years M>35,F>45	x (>45)	x (>35)	x	x	x (<75)	x (<75)	**x**
Tobacco Screening	Non-smoker	x	x	x	x	x	x	**x**
Infectious Disease								
Tetanus/Diphtheria/ Pertussis Vaccine	Tdap once then Td every 10 years	x	x	x	x	x	x	**x**
Influenza Vaccine	Yearly >50			x	x	x	x	**x**
Pneumococcal Vaccine	Once >65					x	x	**x**
Chlamydia Screening	Yearly 18-25	x (<26)						**x**
Metabolic, Nutritional and Endocrine								
Osteoporosis	Every 3 years >65					x		**x**
Diabetes	Every 3 years >45	x (>45)	x (>45)	x	x	x	x	**x**
Obesity	BMI in EPIC	x	x	x	x	x	x	**x**
Substance Abuse								
Alcohol Misuse	Assess alcohol intake - Social History Completed	x	x	x	x	x	x	**x**
MAXIMUM NUMBER OF BUNDLE MEASURES FOR EACH AGE/SEX CATEGORY		9	6	10	9	11	10	

Improving Preventive Care for 219,389 Patients

	11/07	7/11
Adult Preventive Bundle	9.2%	31%
Breast Cancer Screening (q 2 40-49, q 1 50-74)	46%	61%
Cervical Cancer Screening (q 3 yr Age 21-64)	64%	71%
Colon Cancer Screening (Age 50-84)	44%	66%
Prostate Cancer Discussion (Age 50-74)	72%	77%
Lipid Screening (Every 5 yr M > 35, F > 45)	75%	87%
Diabetes Screening (Every 3 yr > 45)	85%	90%
Obesity Screening (BMI in Epic)	77%	97%
Documented Non-Smokers	75%	79%
Tetanus Diphtheria Immunization (every 10 yr)	35%	72%
Pneumococcal Immunization (Once Age >65)	84%	87%
Influenza Immunization (Yearly Age >50)	47%	60%
Chlamydia Screening (Yearly Age 18-25)	22%	37%
Osteoporosis Screening (every 3 yr Age > 65)	52%	73%
Alcohol Intake Assessment	84%	91%

Macrovascular

Stroke

- Non-Bundled Care
- Cumulative risk reduced 13%

- *Bundled Care cumulative risk reduced 17%*
- *31% better*

MI

- Non-Bundled Care
- Cumulative risk reduced 25%

- *Bundled Care cumulative risk reduced 31%*
- *24% better*

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Microvascular

Retinopathy

- Non-Bundled Care
- Cumulative risk reduced 22%

- *Bundled Care cumulative risk reduced 30%*
- *36% better*

Amputation

- Non-Bundled Care
- Cumulative risk reduced 20%

- *Bundled Care cumulative risk reduced 60%*
- *300% better*

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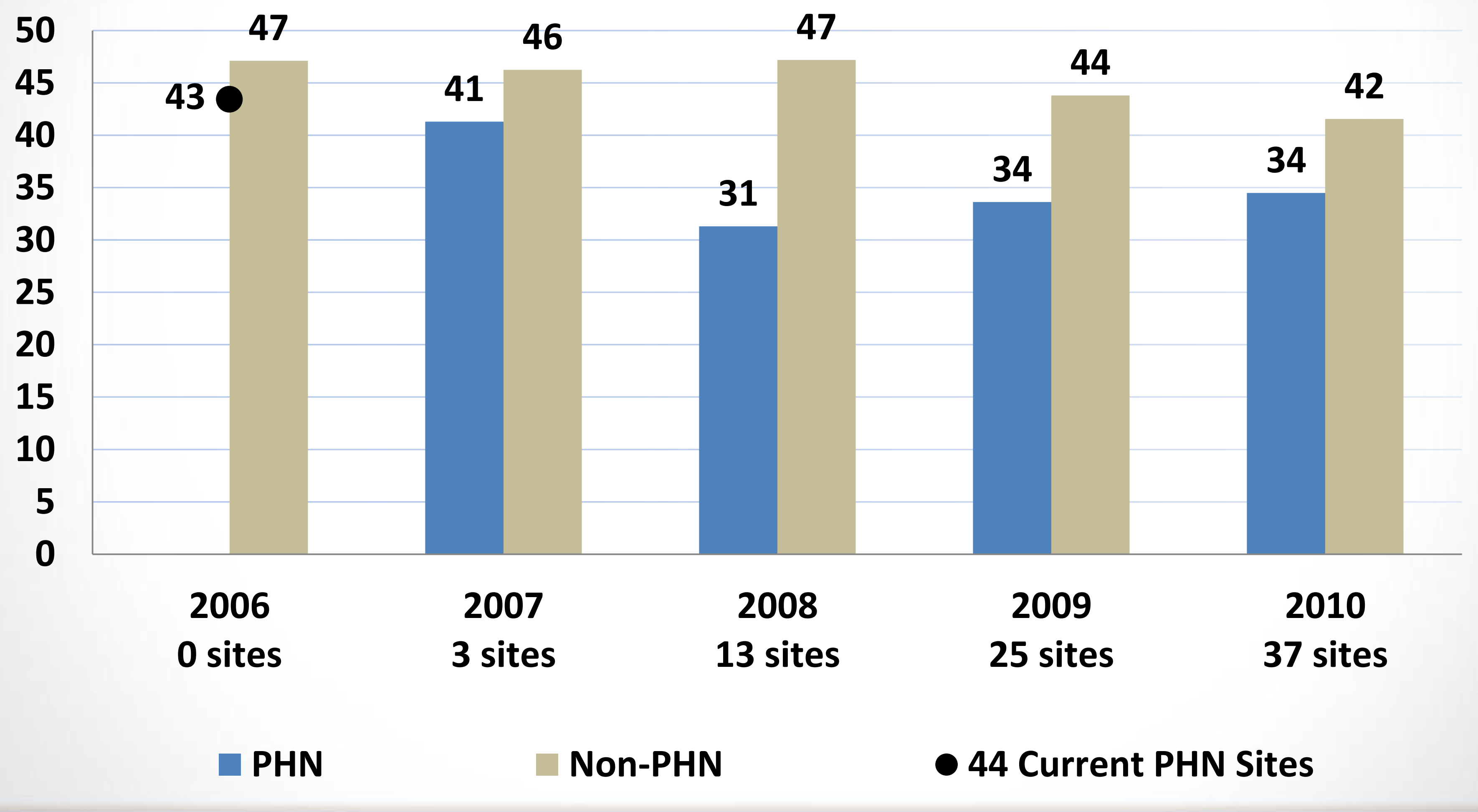
Readmissions are also lower



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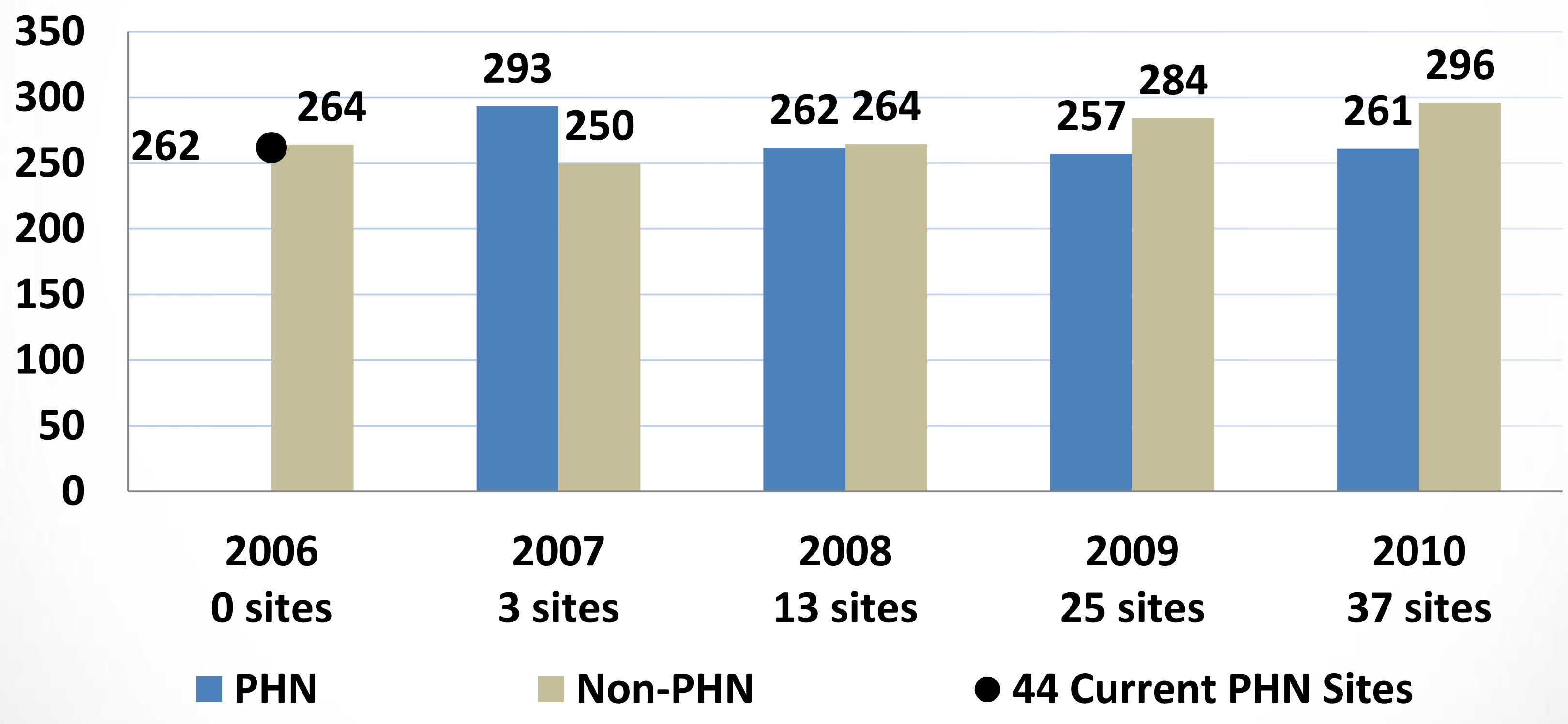
ER stays flat while un-managed increases



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REDEFINING BOUNDARIES®

COPD Metrics

Phase 1 Medicare

	2006	2007	2008	2009	% Change Baseline - 2009
COPD Phase 1 Medicare OP ER/	440.3	498.1	568.1	485.9	10.4%
COPD Phase 1 Medicare IP Adm	945.0	846.2	844.0	734.0	-22.3%
COPD Phase 1 MedicareIP MedS	142.3	165.0	140.7	97.2	-31.7%

Phase 2 Medicare

		2007	2008	2009	
COPD Phase 2 Medicare OP ER/1000		459.1	403.6	479.7	4.5%
COPD Phase 2 MedicareIP Admits/1000		929.4	787.7	876.3	-5.7%
COPD Phase 2 Medicare IP MedSurg Readmi		163.6	103.1	130.5	-20.2%

Phase 3 Medicare

			2008	2009	
COPD Phase 3 Medicare OP ER/1000			472.9	507.7	7.4%
COPD Phase 3 Medicare IP Admits/1000			949.5	860.1	-9.4%
COPD Phase 3 Medicare IP MedSurg Readmits/1000			179.4	127.8	-28.8%

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CHF Metrics

CHF Phase 1 Medicare

	2006	2007	2008	2009	% Change Baseline - 2009
CHF Phase 1 Medicare OP ER/10	629.9	654.4	836.9	732.1	16.2%
CHF Phase 1 Medicare IP Admits	1,380.5	1,175.4	1,367.0	1,217.4	-11.8%
CHF Phase 1 Medicare IP MedSu	285.9	233.4	239.1	214.4	-25.0%

CHF Phase 2 Medicare

		2007	2008	2009	
CHF Phase 2 Medicare OP ER/1000		645.9	546.7	558.0	-13.6%
CHF Phase 2 Medicare IP Admits/1000		1,432.8	1,071.3	1,155.6	-19.3%
CHF Phase 2 Medicare IP MedSurg Readmits		277.2	149.5	167.4	-39.6%

Phase 3 Medicare

			2008	2009	
CHF Phase 3 Medicare OP ER/1000			563.2	654.7	16.2%
CHF Phase 3 Medicare IP Admits/1000			1,181.7	1,155.5	-2.2%
CHF Phase 3 Medicare IP MedSurg Readmits/1000			190.0	139.6	-26.5%
*** baseline year					

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Value Reimbursement Program

- Practice Redesign: Pay for Performance
  - Geisinger Primary Care Physicians earn 10-20% of salary based on quality performance
  - $8,000/year available for Diabetes, CAD and Adult Prevention Incentives
- Geisinger Health Plan Patients
  - About 50% cared for by Geisinger Clinic Physicians
  - About 50% cared for by Panel Physician
  - About 30% of Geisinger Clinic patients are GHP
  - HEDIS scores should be a fair comparison

HEDIS 2010

Cardiovascular Conditions		GHP	Clinic	Panel		
LDL control	69.63%	65.31%	70.56%	60.00%	Statistically Higher	P=0.0278
BP Control	72.68%	74.58%	83.80%	68.40%	Statistically Higher	P=0.0012
Beta Blocker	83.83%	100.00%	100.00%	100.00%		
Diabetes						
Comprehensive Diabetes Care:						
HbA1c tested	92.94%	93.05%	95.86%	89.88%	Statistically Higher	P=0.0080
Lipid control	54.95%	54.48%	57.93%	50.58%	Statistically Higher	P=0.0364
Diabetic Eye	70.79%	67.09%	80.69%	51.75%	Statistically Higher	P<0.0001
Microalbuminuria	88.27%	89.58%	92.76%	85.99%	Statistically Higher	P=0.0088
Blood Pressure <130/80	42.64%	45.52%	51.38%	38.91%	Statistically Higher	P=0.0037

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Cumulative percent difference in spending attributable to PHN

0%
-2%
-4%
-6%
-8%
-10%
-12%

Q1 2005
Q3 2005
Q1 2006
Q3 2006
Q1 2007
Q3 2007
Q1 2008
Q3 2008
Q1 2009
Q3 2009

95% Confidence Interval
Median Estimate
95% Confidence Interval

Cumulative percent difference in spending (Pre-Rx Allowed PMPM $) attributable to PHN in the first 21 PHN clinics for calendar years 2005-2009. Dotted lines represent 95% confidence interval. P = < 0.003

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Lessons Learned Along the Way

It is possible to improve patients' health while reducing costs

- Requires change in primary care delivery model; the change is not easy
  - Needs active, engaged providers
  - Needs active, empowered team
- Transitions of care create specific gaps and opportunities
- Critical to have case manager embedded in primary care site
- Linkage to every system of care needed
- Payer/provider partnership essential to success

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Effective Redesign & Care Coordination Delivers Rapid Impact

Activity	Expected Impact	Time to Impact
Short term effects		
Transitions of Care Management	Reduce Readmissions	3 months
Case management for high risk patients with targeted conditions: DM, HF, COPD	Reduce primary admissions & ED	3 – 6 months
Case Management for other high risk patients	Reduce primary admissions & ED	6-12 months
Pharmacy management	Increase generic use	6 – 12 months
Mid-term effects		
Nursing home management	Reduce readmissions/primary admissions	12 – 18 months
More efficient specialists and ancillary providers	Decrease cost per episode of care	12-18 months
High-end imaging	Reduce unnecessary testing	12 – 18 months
Longer term effects		
Interventions for low risk chronic disease patients: disease registries; chronic disease care optimization	Improved control; avoid complications	2 - 5 years
Preventive care; screening; lifestyle change; wellness	Earlier identification & treatment; decrease incidence of chronic diseases	2 – 5 + years

PHN brings national attention to Geisinger

Chicago Tribune

denverpost.com
The Denver Post

boston.com
The Boston Globe

The Philadelphia Inquirer

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The New York Times

Business Day

TUESDAY, JUNE 22, 2010

Paying to Cut Health Costs

Extra Nurses Help Doctors Keep Patients Out of the Hospital

By REED ABELSON

Like a lot of doctors, Patrick Kilduff has too many patients and too little time. He and the five other physicians in Shavertown, Pa., oversee the care of about 12,000 people, and a typical office visit lasts just 15 minutes.

Because health insurers pay him as little as $45 per visit, Dr. Kilduff and his colleagues say they have little choice but to squeeze as many patients as they can into their day. That makes it virtually impossible to spend time explaining to patients the importance of keeping their blood sugar under control or how to take their medicine. But the insurers' penny-wise approach can lead to as much as $1 million in hospital bills, if a person with under-treated diabetes has a heart attack.

That is why some of the nation's insurers are now trying to avoid those high medical bills by taking the longer view. They are giving primary care doctors more help — and more money — to take care of the sickest patients and help prevent them from becoming sicker.

Otherwise, insurers know they risk being overwhelmed by rising health care costs as an older, sicker population copes with serious chronic conditions.

"The essential business model of medical insurance will have to change," said Dr. Glenn D. Steele Jr., the chief executive of Geisinger Health System, which operates a network of clinics and hospitals in Pennsylvania.

Geisinger is known nationally for its innovative approaches to delivering high-quality care at lower cost. It also owns a health insurance plan that covers about 250,000 people — including many of Dr. Kilduff's patients in Shavertown.

As an insurer, Geisinger now pays the salaries of extra nurses in doctors' offices, whose full-time job is to help patients with chronic diseases stay on top of their conditions and, ideally, out of the hospital. The doctors, including Dr. Kilduff, help hire the nurses, who work closely with the doctors to oversee the patients' care.

LAURA PEDRICK FOR THE NEW YORK TIMES

Dr. Richard Martin touches base with a patient, Marie Jones, as Mary Solomon, right, a nurse, goes over her health details. Geisinger Health System pays for nurses to manage the care of the sickest patients in hopes of avoiding costly hospital stays.

The nurses make sure patients who need quick appointments are squeezed in, and they alert the doctors to any early indications of trouble by keeping in close contact with the patients and looking out for the results of patients' lab tests.

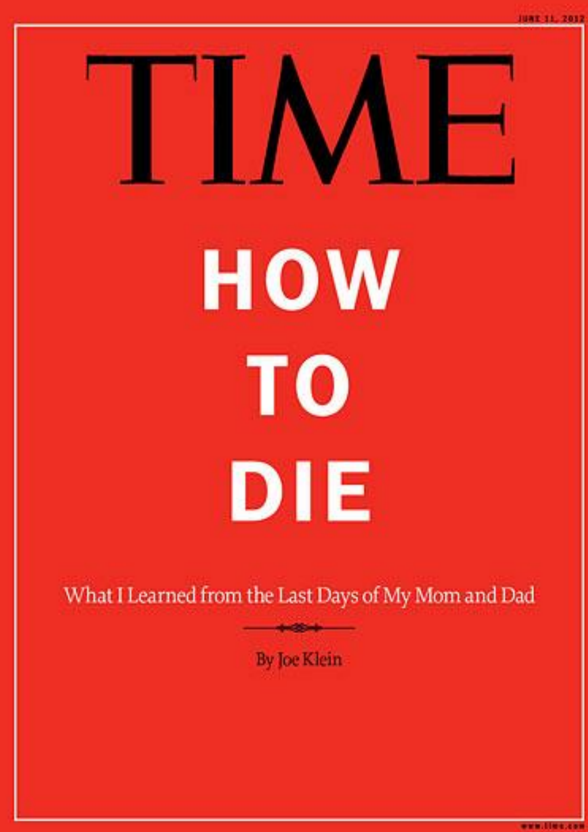
One of Dr. Kilduff's patients, Rose Ann Cox, 69 years old, began working a few years ago with a Geisinger-paid nurse, Karen Thomas, to control her diabetes, talking by phone at least once a week. Ms. Cox had gone to the emergency room when her blood sugars were too low, but she has not been in the hospital for about three years now.

"You don't always think you should call the doctor," Ms. Cox said. But she has no qualms about reaching out to the nurse.

The initiative is part of an overall effort by Geisinger and other insurers to create a so-called medical home — the place where patients' care is carefully coordinated by a doctor and staff, with particular attention given to the chronically ill.

Geisinger began experimenting with this approach three and a half years ago and now uses it in 37 practices, most of which are part of its own network of doctors' offices.

But five of the doctors' offices, including Dr. Kilduff's, are independent practices that accept Geisinger as one of several insurance plans. Under the arrangement with the outside doctors, Geisinger pays for the nurses and shares with the doctors any savings they can achieve by reducing medical expenses. So far, Geisinger says it is pleased with the early results. In an unpublished review of 2008 data, Geisinger experienced



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Healthcare Is Complex Bundle of Data

“The data speaks for itself, but sometimes you have to encourage it to speak”

..and that’s the rest of the story

Unintended consequences

You don’t know what you don’t know

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AMGA-Press Ganey Coordinated Care Survey Pilot Results

Patients love their providers	Top Box	Top Two
Section Roll Up	55%	81%

Patients don't feel their care is well coordinated	Top Box	Top Two
Section Roll Up	30%	42%

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COORDINATED CARE	Top 2 Box Percent		Variance
	Geisinger	All	
My Provider's clinic makes it easy for me to access my personal health record online	66.67%	50.76%	15.91%
My Provider's clinic makes it easy for me to access lab/test results electronically (email, internet, etc)	72.09%	55.42%	16.67%
When I was directed to visit (walk-in, appointment, etc.) another health care facility, I was given clear written instructions	78.31%	69.61%	8.71%

THE PROVIDER AND YOU	Top 2 Box Percent		Variance
	Geisinger	All	
My Provider does a good job helping me understand my health condition	90.00%	94.79%	-4.79%
If needed, my Provider helps me understand any treatment (risks, benefits, etc.)	85.85%	93.20%	-7.35%
My Care Provider encourages me to participate in any treatment decisions	80.39%	89.19%	-8.79%

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COORDINATED CARE	Top 2 Box Percent		
	Geisinger	All	Attendees
My Provider's clinic makes it easy for me to access my personal health record online	66.67%	50.76%	
My Provider's clinic makes it easy for me to access and lab/test results electronically (email, internet, etc)	72.09%	55.42%	
When I was directed to visit (walk-in, appointment, etc.) another health care facility, I was given clear written instructions	78.31%	69.61%	

THE PROVIDER AND YOU	Top 2 Box Percent		
	Geisinger	All	Attendees
My Provider does a good job helping me understand my health condition.	90.00%	94.79%	
If needed, my Provider helps me understand any treatment (risks, benefits, etc.)	85.85%	93.20%	
My Care Provider encourages me to participate in any treatment decisions	80.39%	89.19%	

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Utilizing Patient Reported Data

20% of respondents say they have financial concerns that prevent them from taking proper care of themselves

97% of respondents say they follow the instructions given to me by medical providers who care for me

20% of respondents say they have personal concerns that prevent them from taking proper care of themselves

90% of respondents say they take an active role in improving my health (e.g., diet, exercise, getting enough sleep, etc.)

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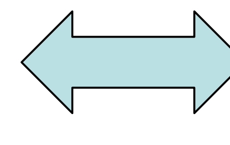
My Provider does a good job helping me understand my health condition
Provider helps me make better healthcare decisions
When Provider speaks with me, it is clear he/she is concerned about my emotional needs
If needed, my Provider helps me understand any treatments (risks, benefits, etc.)
Provider gives me clear instructions on how to care for myself
If my Care Provider recommends I see a specialist/another doctor, she or he explains the reason
Before ordering any medical tests, my care provider discusses these with me



CGCAHPS question: Rate this physician from 1 - 10

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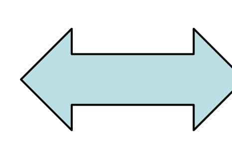
My Provider's clinic provides me a way to get answers to my questions even when the office is closed
The online tools that my Provider's clinic makes available to me meet my needs
My Provider's clinic makes it easy for me to access my personal health record online
When I first made contact with the other facility, the person that greeted me made me feel that they understood why I had made contact
When my visit(s) were complete, I was advised that my results would be shared with the clinic that had made the referral
My health care is well-coordinated between all of the providers who care for me
My Provider and care teams involved with my care seem to be aware of what other health professionals have done for me



CGCAHPS question: Rate this physician from 1 - 10

Care Staff helps me understand how to handle health problems that may arise between visits
Care Staff makes me aware of any additional resources available to help me improve my health
Care Staff encourages me to contact them if I have questions between my scheduled visits
Care Staff helps me understand how to handle health problems that may arise between visits
Before ordering any medical tests, my care provider discusses these with me
My Provider does a good job helping me understand my health condition
If needed, my Provider helps me understand any treatment (risks, benefits, etc.)
My Care Provider encourages me to participate in any treatment decisions
If my Care Provider recommends I see a specialist/another doctor, she or he explains the reason
Provider helps me make better healthcare decisions
Provider gives me clear instructions on how to care for myself
When Provider speaks with me, it is clear he/she concerned about my emotional needs
My Provider does a good job helping me understand my health condition
Before ordering any medical tests, my care provider discusses these with me
If needed, my Provider helps me understand any treatment (risks, benefits, etc.)

In the last 12 months, how often did this provider show respect for what you had to say?

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QUESTIONS?

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