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Developing a Department of Practice Transformation

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Assistant Medical Director of Quality

AMGA
March 16, 2013

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Agenda

Part I – Robert Brenner, MD, MMM, CMO

- Brief Overview of Summit Medical Group
- A New Economic Model
- Large Multispecialty Group Approach
- Organizational Requirements
- Organizational Challenges

Part II – Jamie Reedy, MD, MPH, Medical Director of Practice Transformation

- Goals of Department of Practice Transformation
- Departmental Responsibilities and Resources
- Departmental Challenges
- Overview of Projects
- Specific Examples

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Part I

Organizational Change

Summit Medical Group

- Began in 1929 in Summit, NJ
- Location:
  - Central NJ
  - 22+ sites throughout 5 counties
  - 250,000 sq. ft. main campus
- Services:
  - 340+ Providers (240 Physicians, 100 midlevels/other)
  - 70 different specialties
  - Diagnostics: Lab, X-ray
  - UCC, ASC
- Governance
  - For Profit
  - Physician Owned
  - Physician Leadership
- Key Statistics:
  - Manage 200,000+ Patients with 70,000+ visits/month
  - Collections projected to be $300M in 2013
- Growth
  - 60+ physicians per year
  - 250, 000 sq. ft. in three major hubs under development

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A New Economic Model

From Fee For Service to Demonstrating Value

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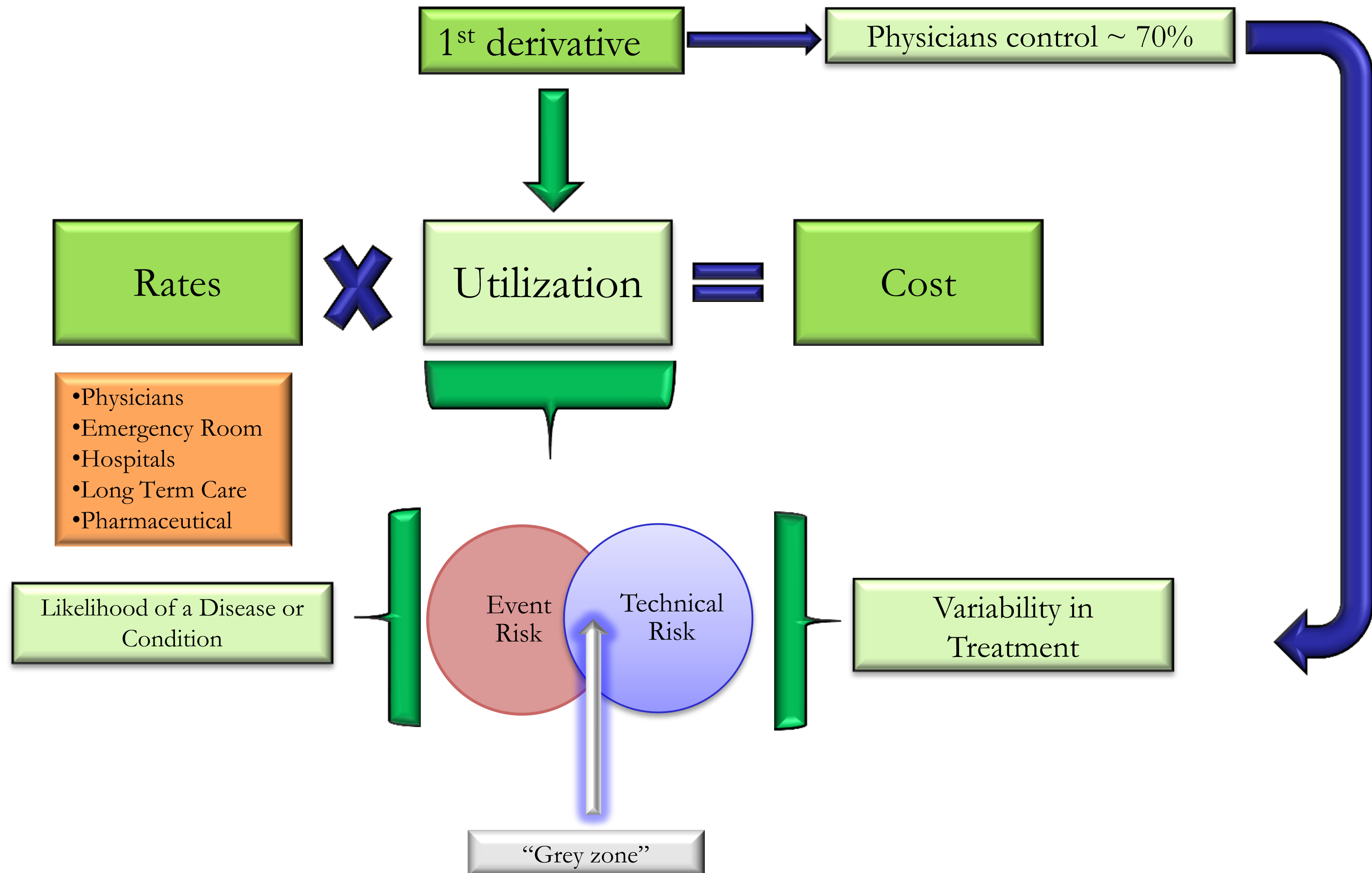
The Current “Economics” of Healthcare



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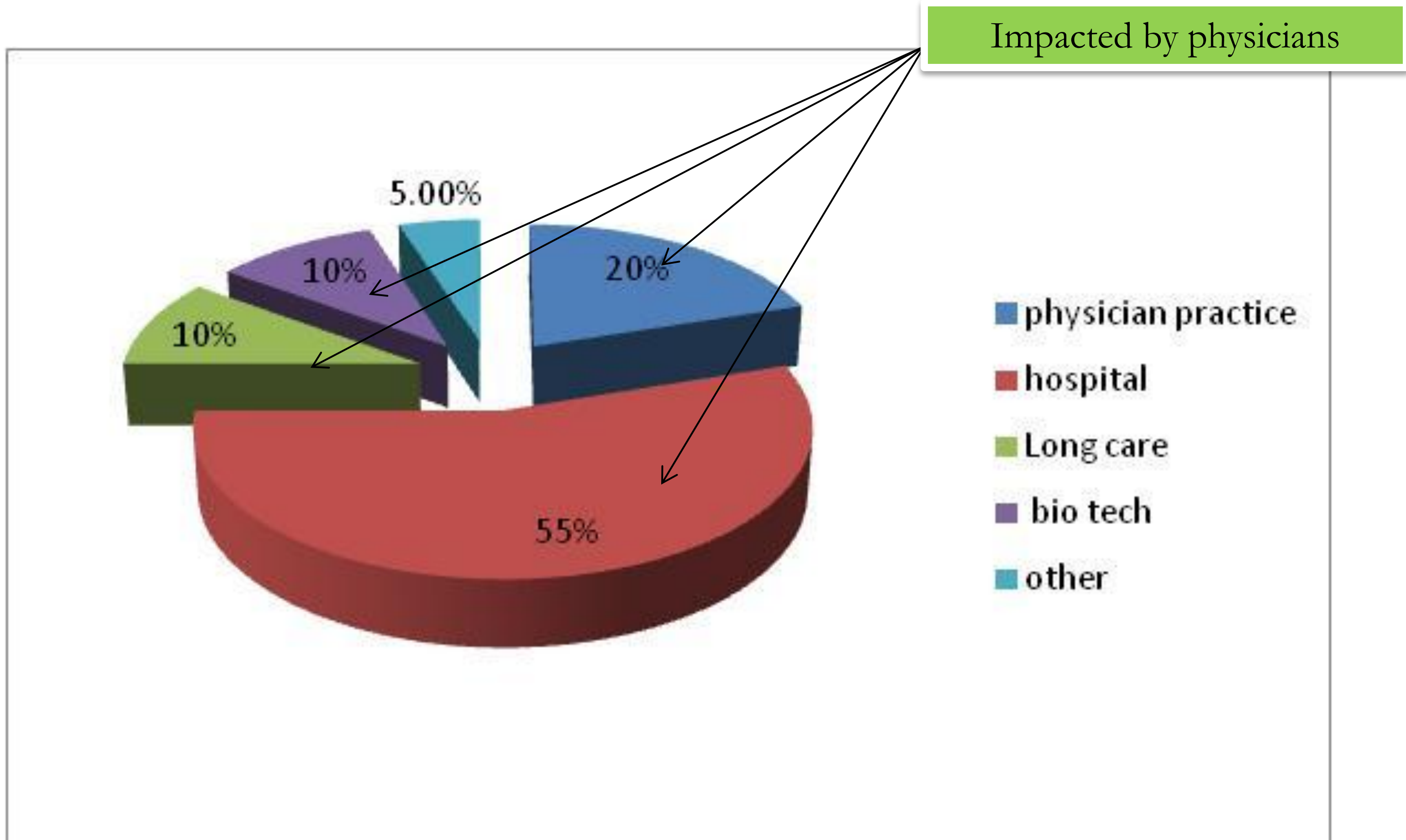
Healthcare Cost Distribution



Physicians impact > 70% of Healthcare costs!

Donald Berwick's Triple AIM

Improving Care for Individuals

Lowering the Cost of Care

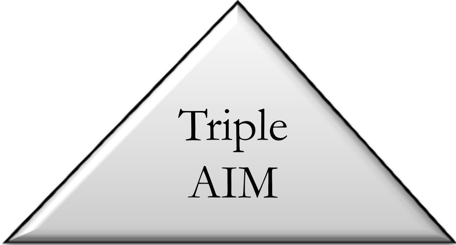
Improving Health of Populations

Patient Engagement

Financial Viability

Value-Based Contracting

Value = Quality ÷ Cost



AIM #1: Reduced Spending

AIM #2: Improved Care for Individuals

AIM #3: Better Health for Populations

If Lower Costs ?

Benchmark

Risk is Shifting from Insurers to the Providers of Health Care

Emergence of Value-Based Contracting

Center for Medicare and Medicaid Services and Commercial Variations

- One Sided Shared Savings (Upside Only)
- Two Sided Shared Savings (Both Upside/Downside)
- Full Risk Contracts (i.e. CMS Pioneer Program)
- Patient-Centered Medical Home
- Bundled Payments (Devices/Meds/Rehab)

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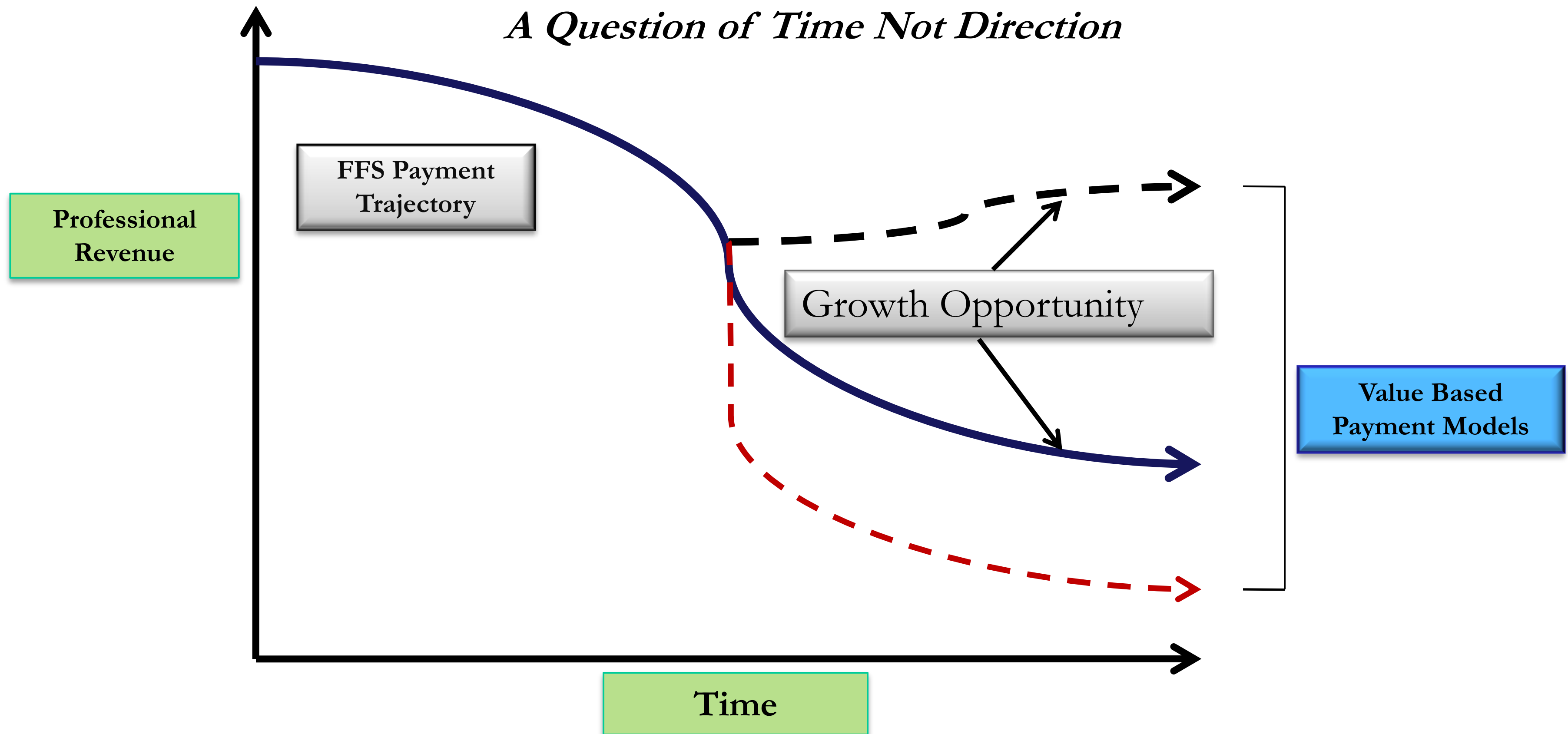
A New Economic Model



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Large Multispecialty Group Approach

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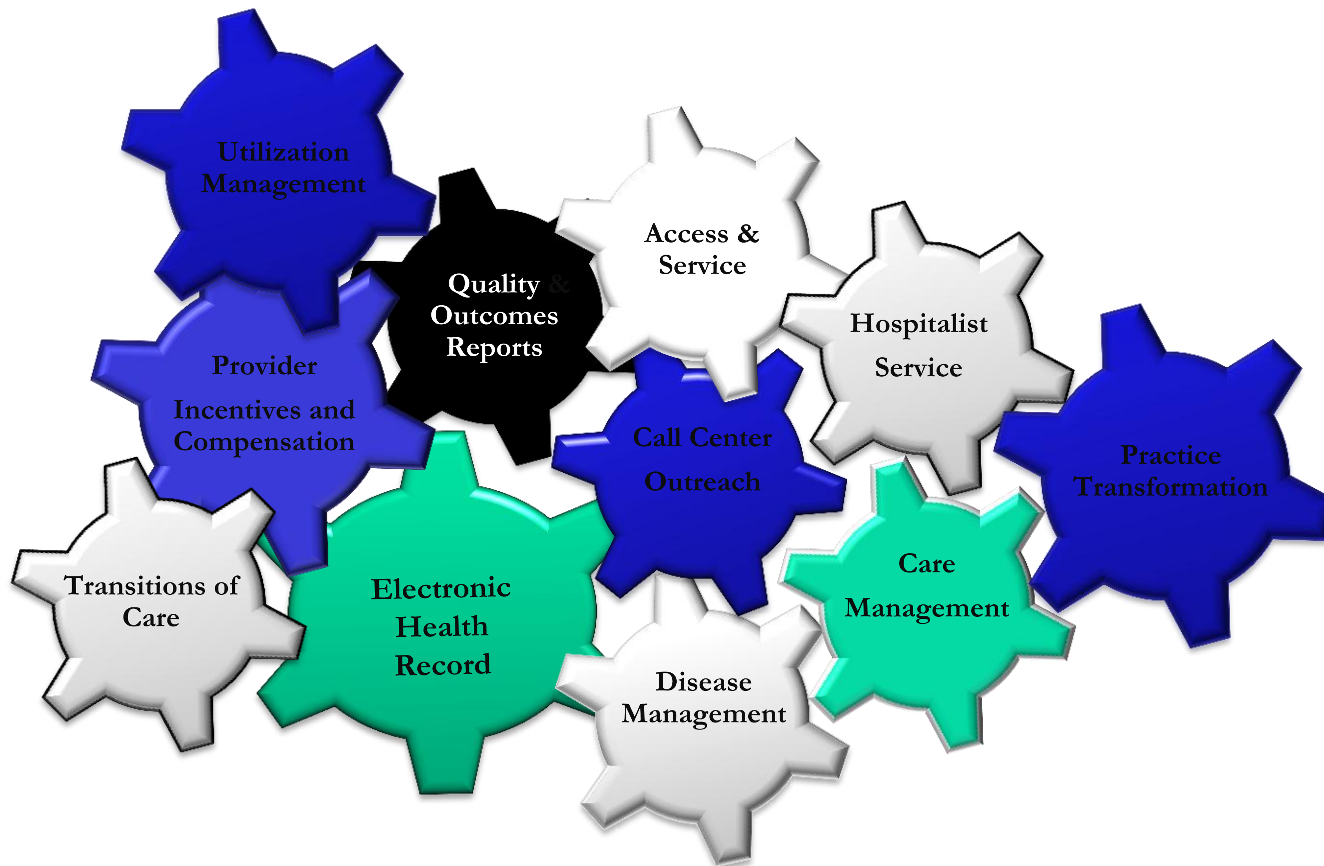
Integrated Care

Managing Value as an Organizational *Core Competency!*



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Essential Human Resources

- Medical Director of Practice Transformation/Clinical IT Champion
- Clinical Manager of Care Management
- Medical Director and Manager of Quality
- Strong ties with IT Department
- Support from Training Department
- Support from Clinical Operations

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Essential Infrastructure

- Information Technology
  - Electronic Health Record
    - Meaningful Use
    - Retrievable Data Fields
    - Query Tools
  - Data Warehouse and Analytics
  - Patient Portal/Mobile Contact

- Care Management/Population Health Management Tools
  - Risk Adjustment and Cost of Care Estimation
  - Care Management Registry; Identify gaps in care
  - Quality Dashboards

- Business Intelligence/Reports
  - Point of Care Reports: Drive comprehensive visits
  - Provider Summary Reports: Feedback for physicians is critical to behavior change.
  - Clinical Department vs. Group Outcomes on costs and quality
  - By Payer Contract/Program

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Organizational Requirements

- Leadership – Setting the Vision
- Cultural Alignment
- Financial Investment
- Operational Alignment
- Readiness for Change
- Burning Platform

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Organizational Challenges

- Developing a Population Health Strategy
- Competing Economic Models
- Change Management ⟷ Culture
  - Communication
  - Pace of Change
  - Alignment of Internal Incentives
- Compensation Formula
- Department Silos
- EEHR Implementation and Adoption

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Part II

A New Department

Requirements for Transformation Success

- Incentive: Reformed Payment Models
- Process: Care Management Strategy
- Tools: HIT

Department of Practice Transformation

- Department Mission
- Reasons for Developing a Separate Department
- Responsibilities
- Human Resources
- IT Resources
- Examples of Projects and Successes

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Department Mission

- To support the provision of high-quality, evidence-based, patient-centered care.
- To prepare SMG to participate in value-based contracts.
- To reduce the overall cost of care for our population.
- To develop care management as a core competency.

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Why A New Department?

- Nidus for all Transformation Efforts
- Visibility
- Internal and External Validation
- Transparency
- Financial Commitment
- Resource Allocation

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Areas of Accountability

- Practice Redesign
- Payer Contract Requirements
- Care Management Program
- CMS Regulatory Compliance and Incentive Programs
- Clinical IT Solutions

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Department Responsibilities

- Maintain and advance PCMH model in primary care.
- Standardize evidence-based clinical guidelines across primary care.
- Ensure success of value-based contracts:
  - Patient attribution
  - Quality metric measurement and reporting
  - Care management initiatives
  - Risk adjustment calculations

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Department Responsibilities

- Clinical IT:
  - Advance use of EEHR
  - Align all requests for clinical customization
  - Facilitate discrete data collection
  - Develop data management solutions
  - Care management registry tool
  - Point-of-care tools
  - Clinical decision support to standardize care

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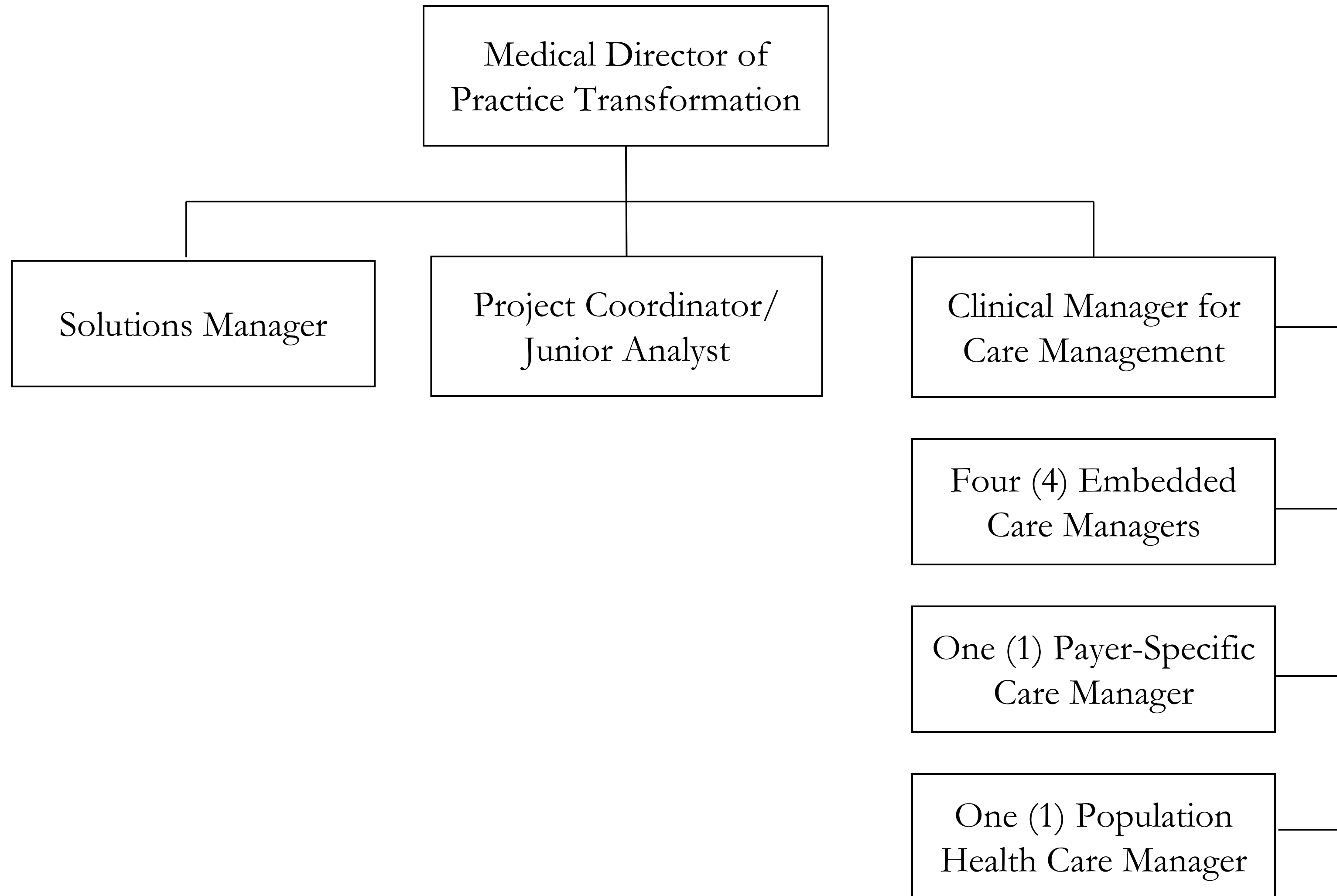
Department Responsibilities

- Care Management:
  - Embedded and Remote Models
  - Education and Training of Care Managers
  - Care Plan Development
  - Transitions of Care – Inpatient and ER
- Disease Management:
  - Current focus on diabetes
  - High cost opportunities: CHF and COPD

Human Resources



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Embedded Care Managers

- A Day in the Life:
  - Transitions of Care:
    - Hospital Discharges
    - ER Visits
  - Identify and Manage High-Risk Patients
  - Close Gaps in Care
  - Social Work-Type Interventions

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Payer-Specific Care Manager

- A Day in the Life:
  - Transitions of Care
    - Daily Notices of Admission
    - Conference call with Payer's RN Case Manager
  - High-Risk Patient Review and Outreach
  - Close Gaps in Care
  - Outreach to PCPs

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Risk Stratification

LEVEL 6 CATASTROPHIC CARE	Does the patient have a catastrophic or complex condition in which his or her health may or may not be able to be restored? Problems: End Organ Damage, > 3 chronic diseases. Medications:: > 5 systemic, > 2 prescribing physicians. Functional: Severe, multiple falls, KPS ≤ 50, frailty, physiologic advanced age. Utilization: Frequent hospitalization, ED, urgent care, readmit within 30 days. Controlled: no. Terminal illness.
LEVEL 5 TERTIARY PREVENTION	Does the patient have multiple chronic diseases, significant risk factors, complications, and/or complex treatments? Problems: End Organ Damage, > 3 chronic diseases.. Medications:: > 5 systemic, > 2 prescribing physicians. Functional: Moderate, single fall, KPS 60 -70. Utilization: Single hospitalization, ED, urgent care. Controlled: yes.
LEVEL 4 SECONDARY PREVENTION	Does the patient have one or more chronic diseases, with significant risk factors, and is unstable or not at treatment goals? Problems: 1 - 3 chronic diseases. Medications: ≤ 5 systemic, ≤ 2 prescribing physicians. Functional: normal. Utilization: none. Controlled: no.

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Risk Stratification (cont'd.)

LEVEL 3 SECONDARY PREVENTION	Does the patient have one or more chronic diseases, with significant risk factors, but is stable or at desired treatment goals? Problems: 1 - 3 chronic diseases. Medications: ≤ 5 systemic, ≤ 2 prescribing physicians. Functional: normal. Utilization: none. Controlled: yes.
LEVEL 2 PRIMARY PREVENTION	Is the patient healthy, but at risk for a chronic disease, or has other significant risk factors? Problems: pre diseases, pre diabetes, elevated BP, border line lipid, etc. Medications: none. Functional: normal. Utilization: none. Controlled: n/a.
LEVEL 1 PRIMARY PREVENTION	Is the patient healthy, with no chronic disease, or significant risk factors? Problems: none Medications: none. Functional: normal. Utilization: none. Controlled: n/a.

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Clinical IT Resources

- Allscripts Enterprise EHR (Jan 2003)
- CQS Clinical Quality Measures Dashboard
- Athena Practice Management (Oct 2011)
- Anodyne Reporting Tool
- Point-of-Care Tool for Primary Care (Jan 2010)
- Crimson Population Risk Management (March 2013)
- Crimson Care Registry (May 2013)

Point of Care Reports

Goals Not Met are highlighted for quick reference and visibility

Diagnoses and **Meds** are prioritized to highlight chronic conditions

Targeted reminders for staff allow better leverage of provider time and meet quality metrics

Labs, Calculations and **Diagnostic Procedures** pertinent to the Action Items are displayed for easy reference

Patient Recommendation Report

33705 TEST PT, HELEN DOB:12/14/1927 Age:81 Sex:F Seen By:N/A
Appointment Date: N/A Report Date:7/20/2009 PCP:DOCTOR, CHARLES E M

Active Diagnoses

ESSENTIAL HYPERTENSION, BRIEF (401.
HYPERCHOLESTEROLEMIA (272.0)
SENILE OSTEOPOROSIS (733.01)
ANX/DEP MIXED (300.4)
CERVICAL DISC DISORDER (722.91)
CONSTIPATION, UNSPECIFIED (564.00)
DEGENERATIVE ARTHRITIS, NOS (715.9
FATIGUE (780.7)
GASTROESOPHAGEAL REFLUX DISEASE
IRRITABLE BOWEL SYNDROME (564.1)
LOWER OBSTRUCTIVE UROPATHY (599.
RESTLESS LEGS (333.99)
SYMPTOM, NAUSEA ALONE (787.02)
VERTIGO, BENIGN (386.11)
MORE

Active Meds

Zocor 20 MG	QD	02/04/09
Bayer Aspirin 325 MG	PRN	09/13/07
Calcium + D 600-200 MG		06/05/06
Calcium-Vitamin D 250-1	QD	07/26/05
Diazepam 10 MG	hs	10/15/08
Lortab 5.5-500 MG	Q 4hr/P	04/21/09
Reglan 10 MG	AC TID	04/21/09

Labs

Trig	132	mg/dL	7/15/09
Chol	209	mg/dL	7/15/09
LDL	126	mg/dL	7/15/09
LDL Direct	134	mg/dL	4/05/05
HDL	57	mg/dL	7/15/09
Gluc, Fasting			
Gluc, Random	131	mg/dL	7/15/09
HbA1c	6		2/24/09
MicroAlb/Cr			
INR			

Measures / Calculations

BP	134/82	7/15/09
	154/80	4/21/09
CHD Risk	8%	
BMI (Wt)	29 (153lb)	7/15/09
Ideal Wt.	102-138	
Est. CrCl	37.26	7/15/09

Diagnostic Testing

Bone Density	6/06/06
Colonoscopy	7/01/08
Mammogram	4/20/05
PAP	4/20/05
Chlamydia	

Vaccine

Tetanus	5/11/94
Tdap	
Pneumoccal	9/25/95
Flu	11/19/08
HPV	
Herpes Zoster	

Risk Factors

CHD 10Yr Risk < 10%
CHD Risk Factors: 2+
HTN Risk: CoMorbid Dx (DM, Renal Dz or Decr Renal Function)
DM Risk: Mod (Metabolic Syndrome)
Pneumonia (Age > 64 OR Risk Dx)
Osteoporosis or Osteoporosis Risk

Goals

Goal not met: CrCl < 60
Goal not met: BP >/= 130/80
Goal not met: Bld Glucose > 125 (Check Fasting Status)
Goal met: BMI < 30
Goal met: LDL < 130
Nonsmoker

Action Items

____Document Advanced Directives status PREV
____Document last Bone Mineral Density test (DXA), if applicable PREV
____Document / administer Tetanus vaccine, if applicable PREV

DOC: Consider evaluation for Diabetes due to Blood glucose > 125 GLUC
DOC: Consider adding Metabolic Syndrome Dx (Dysmetabolic Syndrome X) to Problem List due to 3/5 criteria met (see criteria below) GLUC

MED: Start ACE or ARB for BP goal not met due to CoMorbid Dx (DM or Renal Dz). HTN

PROC: Order or Discuss obtaining Bone Mineral Density test (DXA) (q 2 yrs) for Osteoporosis Dx or Osteoporosis Risk, unless documented today PREV

VAC: Consider Zoster vaccination, unless contraindicated PREV

Insurance: RURAL HEALTH CLINIC I, AARP

Routine Visits: Next Visit: 11/04/2009; Last Visit: 07/15/2009

Comp. Exam Visits: Next Visit: ; Last Visit:

Suggested Next Visit:

12 mos	CHOL
1-3 mos	HTN
3-6 mos	GLUC

Metabolic Syndrome Criteria

- BP > 130/85, OR Dx: Hypertension, OR AntiHTN Med
- Triglycerides > 150
- HDL < 40 Men, < 50 Women
- Glucose > 100
- BMI > 26

*--Unless contraindicated

Key Initiatives

- Population Health Management
  - Centralized Care Management (Registries and Call Center)
  - Managing Preventive Health Process Metrics (Mammograms/Immunizations)
  - Managing Disease-Oriented Outcomes (DM – HbA1C)

- Hospitalist Program
  - Reduce LOS
  - Reduce Readmission Rate
  - Ensure Proper Documentation/Coding
  - Data and Information Analysts

- Transitions of Care Team
  - Geriatric Services
  - Rehabilitation Services
  - Care Management Team
  - TeleHealth

- Team-Based Primary Care (Patient- Centered Medical Home)
  - Embedded Care Coordinator
  - All Staff Functioning at the top of their Licenses

- Diseased-Based Care Management Centers
  - Chronic Diseases: DM/CHF/COPD/HTN – in development
  - High Severity: Breast Disease Center/ Anticoagulation Clinic

Successful Contract Negotiation

- Define Cost Calculation Methodologies
  - Risk Adjustment
  - Comparison Group : Market vs. Historical
  - Catastrophic Exclusions
- Define Patient Attribution Methodologies
  - Plurality of Visits
  - PCP vs. Specialist Visits
  - E&M Code Types
- Ensure Data Sharing Obligations – Claims Level Data is Essential!
- Define Quality, Utilization and Cost-of-Care Metrics
  - Benchmarks
  - Specific Metrics and Measurement Methodology
  - Process vs. Outcomes

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Payer Pilots

- Demonstrating Value
  - PCMH Program
  - ACO 2-Year Pilot

PCMH – ER Visits/1000

Pilot Level Practice Comparison

Incurred January 2011 - December 2011, paid through March 2012 vs. same timeframe in 2010

ER Visits/1000 By Practice

- Performance continues to be favorable across most practices.
- Pilot performance favorable compared to Non PCMH comparison practices's composite performance.
- Milliman's target for Well Managed – 86 ER Visits/1000.

PCMH – IP Admits/000

Pilot Level Practice Comparison

Incurred January 2011 - December 2011, paid through March 2012 vs. same timeframe in 2010

IP Admits/1000 By Practice

- Composite performance decreased 3% when compared to pilot practices the previous year. Medicare Risk decreased 2% while commercial decreased of 7%.
- Pilot current year average vs. Non PCMH comparison practices current year reveals a 19% difference.
- Milliman's target for Well Managed – 41 IP Admits/000.

PCMH – Allowed Medical PMPM

Pilot Level Practice Comparison

Incurred January 2011 - December 2011, paid through March 2012 vs. same timeframe in 2010

PROPRIETARY

Composite Allowed Medical PMPM

Lowest Cost of Care

Bar 1	$372
Bar 2	$387
Bar 3	$400
Bar 4	$339
Bar 5	$513
Bar 6	$450
Bar 7	$336
Bar 8	$342

Axis: 0, 100, 200, 300, 400, 500, 600

SMG PCMH

Pilot Average: Composite data

Non PCMH Comparison Practices Current Year: Composite data

- Composite average Allowed PMPM favorable compared to Non PCMH PMPM
- Practice average PMPM at $382 compared to Non PCMH average of $433
- Most efficient medical home at $336 PMPM
- Medical home with greatest improvement opportunity at $513 PMPM

Reporting based upon claims incurred January 2011 - December 2011 and paid January 2011 - March 2012. High cost claimants included.

Source: HHI Informatics

PCMH – Clinical Quality Performance

Pilot Level Practice Comparison

Incurred January 2011 - December 2011, paid through March 2012 vs. same timeframe in 2010

Clinical Quality Performance

Among the Highest Quality

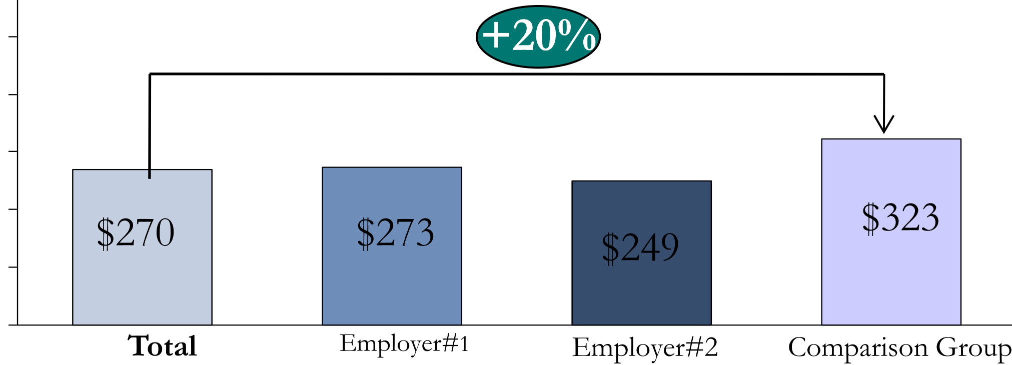
18
14 ▶
9
0

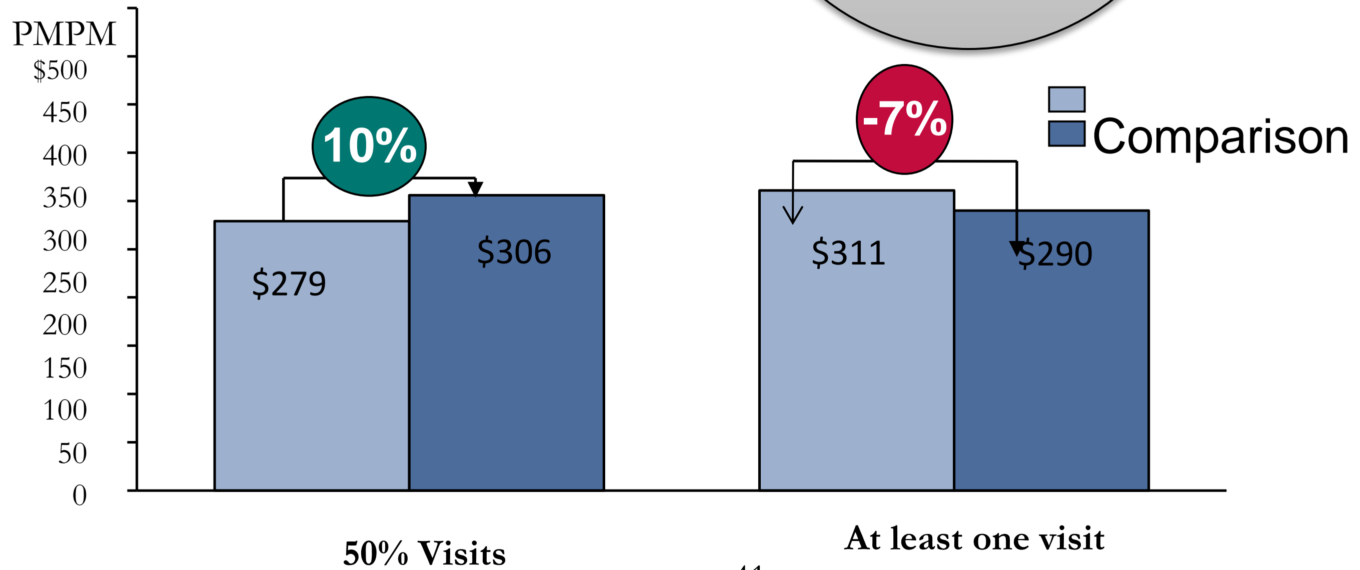
14 14 15 15 13 11 14

SMG PCMH

- Six practices met or exceeded quality threshold (14 out of 18 measures).
- Based upon administrative claims data paid through March 2012 and practice chart data and clinical exclusions shared throughout the program year.

2011 ACO Pilot





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Improving Transitions of Care

Programmatic Redesign and Workflow Changes

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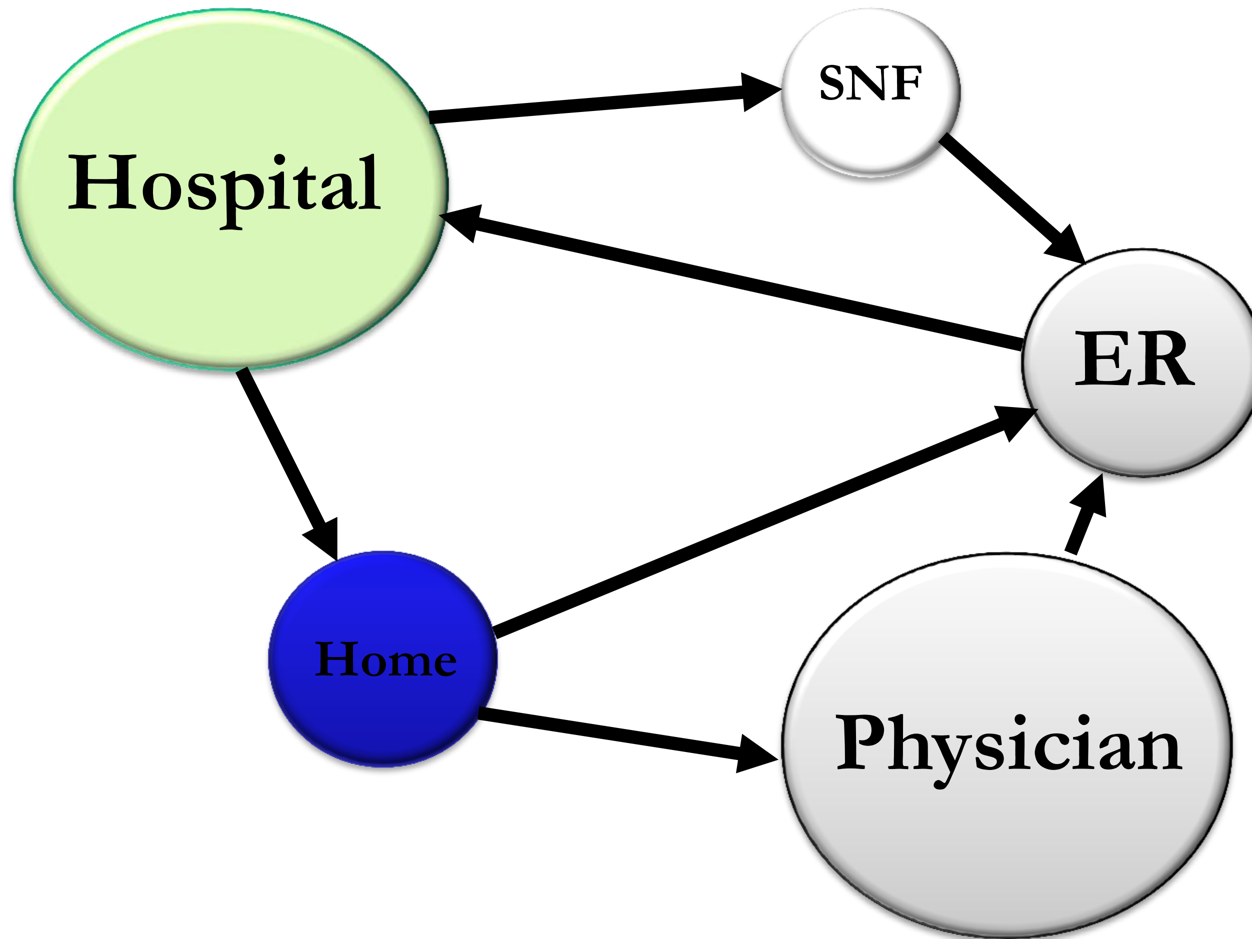
Circles of Unaccountability



Driven by disease exacerbations & gaps in communication, coordination …

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Elements of Redesign

- Goals:
  - Quality Patient Outcomes & Service
  - Quality Physician Services
  - Improved Communication between hospital and PCP
  - Lower Cost (Lower Admissions/Appropriate LOS/Lower Readmission Rate)
- Interventions
  - In-Sourced the Hospitalist Service
    - Midlevel Providers to Facilitate Admissions/Discharge/Communications
    - Inpatient Patient Advocate
    - Hospitalist Continuity of Care Model
    - Direct Admissions from Urgent Care Center (avoid the ED)
    - Alignment of Incentives
    - Risk Stratification
  - Care Management Team to Navigate High Risk Patients, Manage all Transitions
  - Home TeleHealth Program
  - Geriatrician/NP Home Visits
  - Rehabilitation Physician
  - Expand UCC Capacity (↓ Ambulatory Care Sensitive Visits)

Alignment of Incentives: Hospitalist Program Bonus Calculation

Dr. Example

Date Range

Indicator	Value	Potential Points	Threshold Threshold Range		Target Target Range		Maximum Maximum Range		Total Points
Director Evaluation	44.5	20	30	34	35	44	45	50	20
			40%		70%		100%		
LOS	0.95	20	0.99	0.95	0.94	0.92	0.91	0.00	10
			50%		80%		100%		
Readmission Rate	9.51	15	15	13	12	10	9	0	12
< 30 Days (in percent)			50%		80%		100%		
Patient Satisfaction	4.05	15	0.00	4.06	4.06	4.48	4.48	5.00	0
(Benchmark = 4.27)			0%		80%		100%		
SMG Staff Satisfaction	73%	20	61.2%	67.7%	67.7%	74.1%	74.1%	100.0%	16
(% of possible points)			40%		80%		100%		
Productivity Increase	10%	10	5%	9%	10%	14%	15%	100%	8
(Group Goal)			40%		80%		100%		
Total Potential Points		**100**				**Total Points Earned**			**66**

Maximum Bonus	$100,000
% Earned	66%
Earned Bonus	**$66,000**

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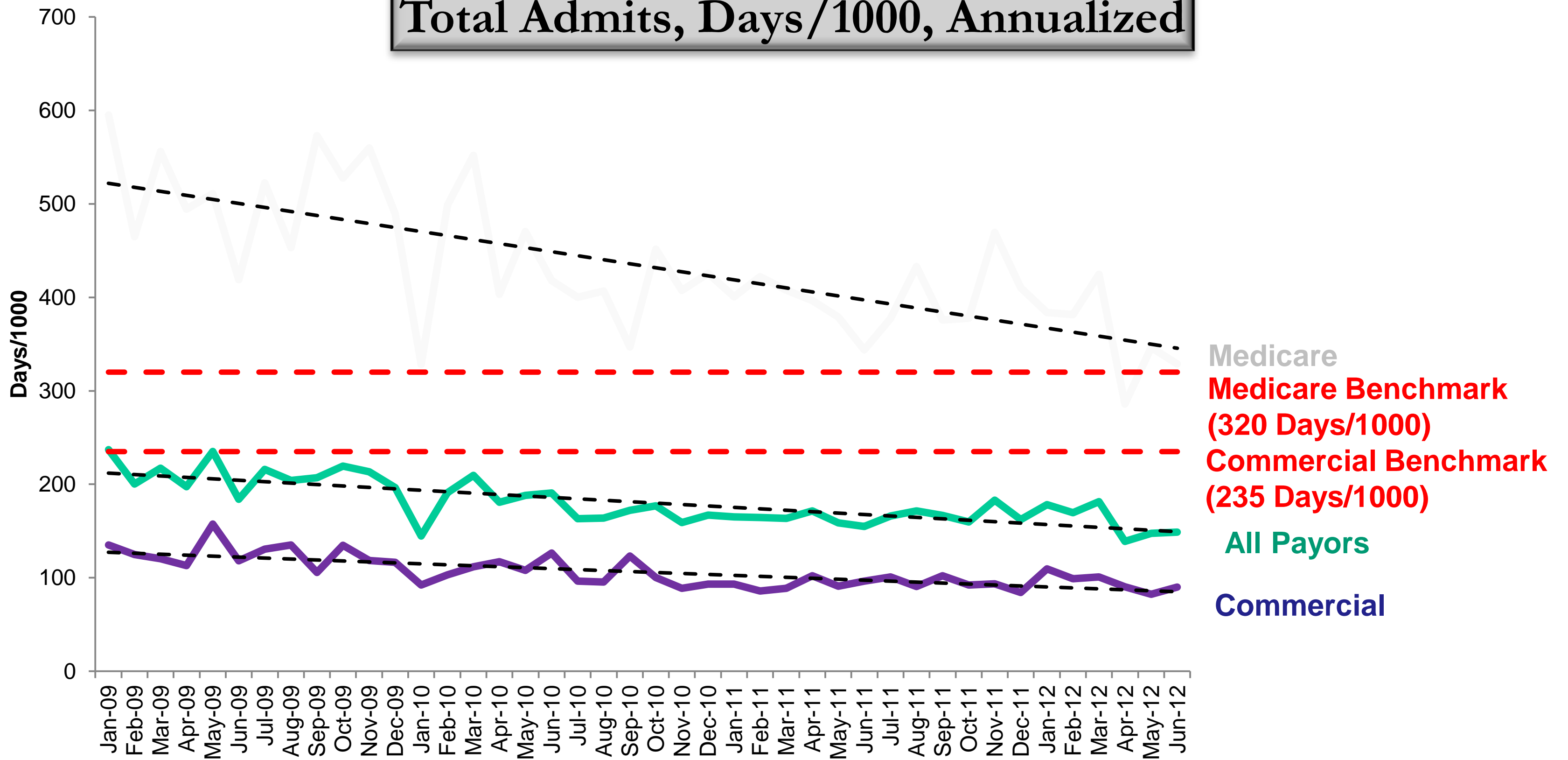

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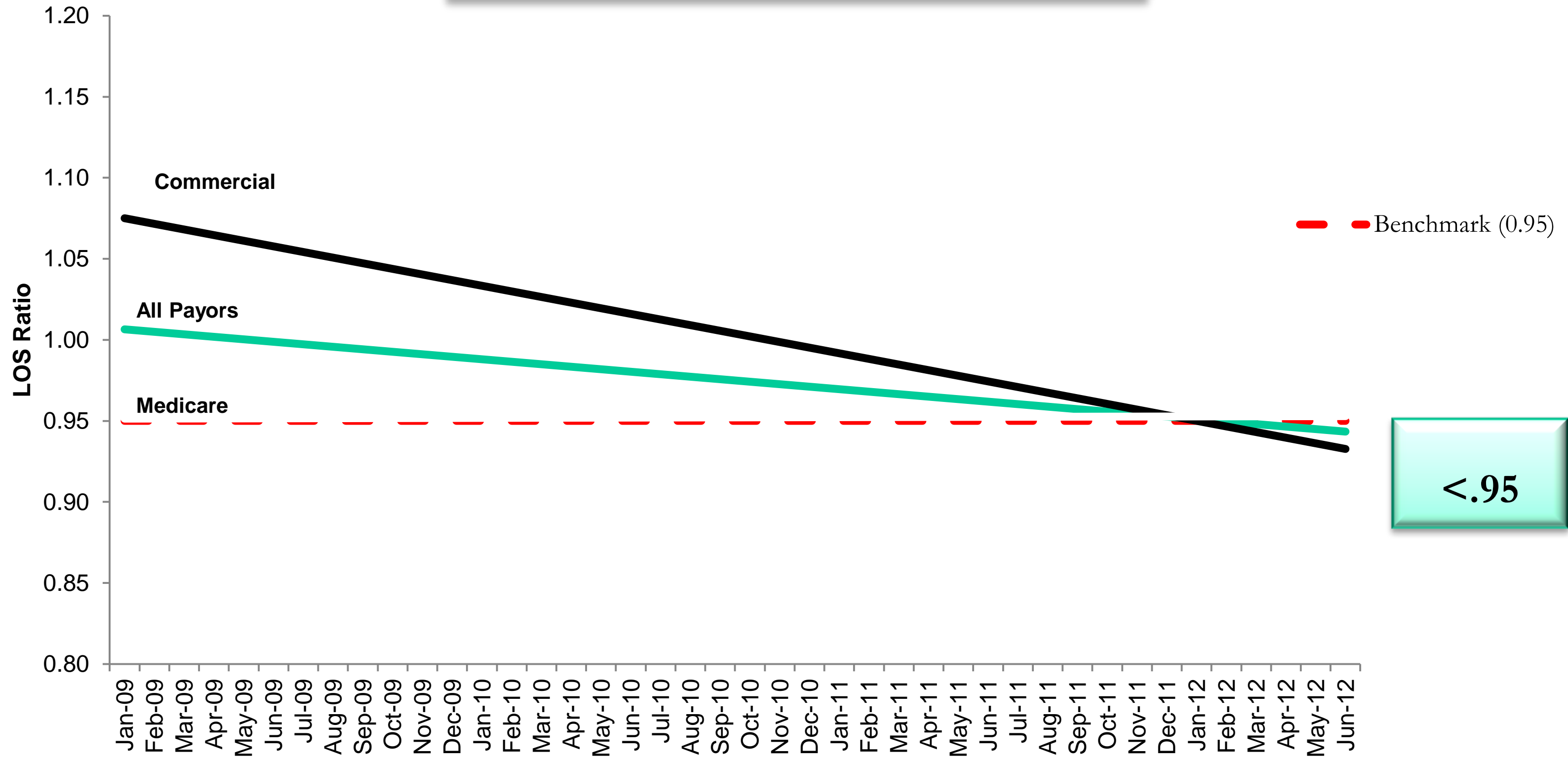
LOS Ratio = Actual/Expected



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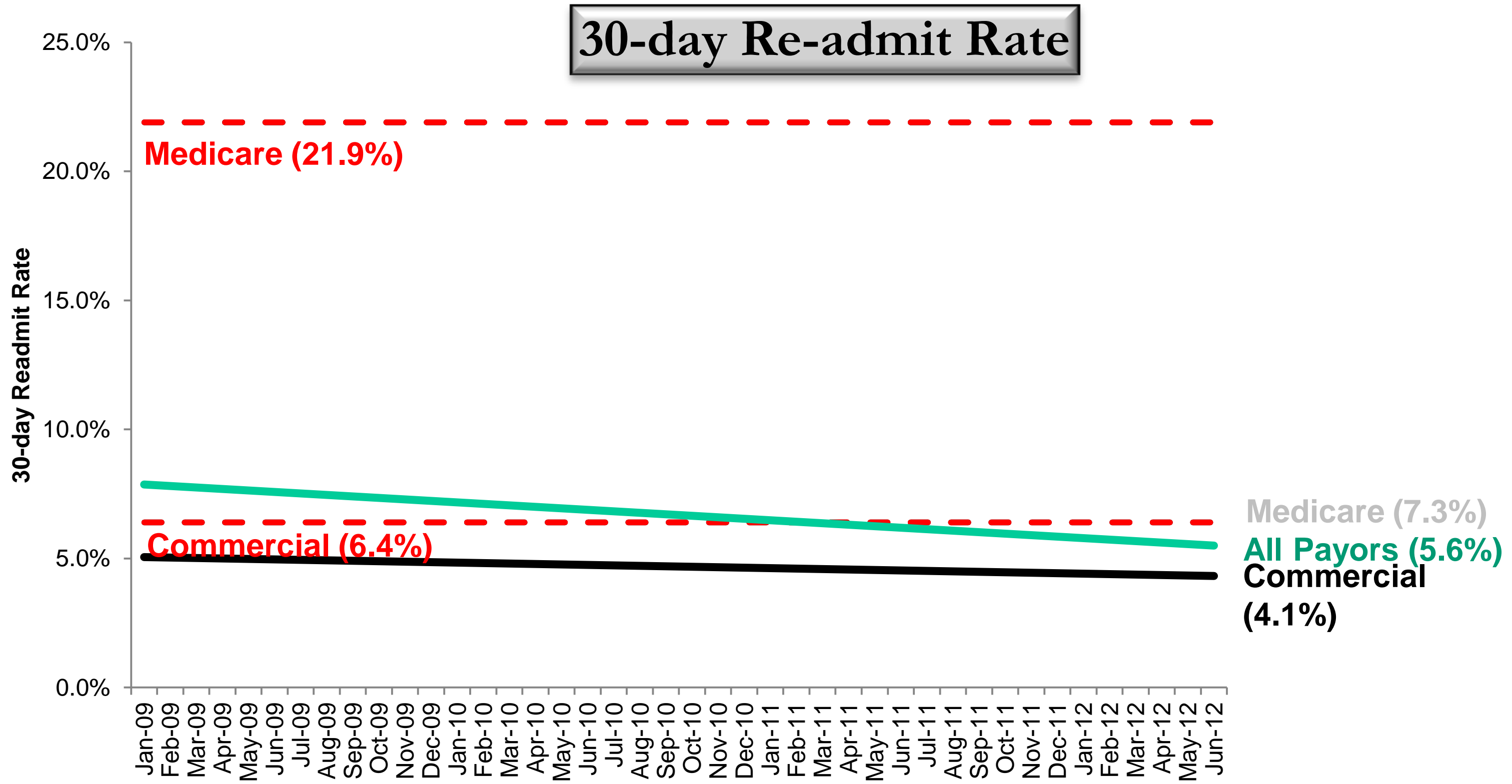

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Estimated Savings From Reduced Bed Days/1000 Patients				
3 Year Savings = $50M				
Year	Total Days	Days/1000	Days Saved	$ Saved
2009	20,559	211		
2010	18,538	176	3,693	$11,077,500
2011	18,912	166	5,130	$15,390,000
2012	20,645	154	7,581	$22,743,000
Totals	**78,654**	**707**	**16,404**	$49,210,500

Assumptions

2009 is base year

NJ Average Cost per day is $3000

Overall ALOS is 3.0

Increase in ambulatory services not in calculus

Population Health

Managing Diabetes Mellitus

Registry Example: Diabetics with LDL >100

Provider: abc

Fname	Prior LDL	Current LDL	Trig	Statin	Medication	Age
Virginia	125	141	254	NO		60
Hilary	101	139	79	NO		55
Anne	113	117	85	NO		60
Josephine	145	114	115	NO		67
Ashok	68	113	123	yes	Lipitor 10 MG	60
Bonnie	72	114	130	yes	Lipitor 10 MG	52
Ruth	111	129	89	yes	Crestor 5 MG	88
Emmy	136	127	204	yes	Simvastatin 40 MG	66
Virginia	168	134	97	yes	Vytorin 10-40 MG	57
Jeanette	91	110	91	yes	Simvastatin 20 MG	77
Brenda	108	109	74	yes	Zetia 10 MG	59
Mercedes	121	178	67	yes	Simvastatin 40 MG	51
Marilyn	208	152	137	yes	Lipitor 80 MG	67
Linda		135	104	yes	Crestor 5 MG	61
Jean	110	151	88	yes	Zocor 20 MG	54
Brenda	121	109	67	yes	Lipitor 20 MG	58

Total Patients	**16**	
On Statin	**12**	**75%**
Not on Statin	**4**	**25%**

no Rx

no persistence

no fulfillment / adherence

Physician Quality Dashboard

Physician Dashboard - Microsoft Internet Explorer provided by Summit Medical Group

File Edit View Favorites Tools Help

Back Search Favorites

Address http://smgcqs01.smg.com/pages/dashboard/dashboard.aspx Go Links

Physician Dashboard

Welcome, tprovider | About | Change Password | Logout

Dashboard

Links

PQRI 2009

Measure	Description	Results	Count
PQRI 1	Diabetes Mellitus: Hemoglobin A1C Poor Control	50% 38% 6% 6%	647 Patients
PQRI 2	Diabetes Mellitus: LDL-C Control	70% 16% 6% 8%	35[illegible] Patients
PQRI 3	Diabetes Mellitus: High Blood Pressure Control	34% 2	360 Patients
PQRI 5	Heart Failure: ACE Inhibitor or ARB Therapy for LVSD		0 Patients
PQRI 6	CAD: Oral Antiplatelet Therapy Prescribed	83% 17%	1399 Patients
PQRI 7	CAD: Beta-Blocker Therapy for CAD Patients with Prior MI		0 Patients
PQRI 8	Heart Failure: Beta-Blocker Therapy for LVSD		0 Patients
PQRI 9	MDD: Antidepressant Med During Acute Phase for New Episode		0 Claims
PQRI 10	Stroke and Stroke Rehab: CT or MRI Reports		0 Claims
PQRI 11	Stroke and Stroke Rehab: Carotid		0 Claims

Legend | Drill Down | Compare | Documentation

Legend - PQRI 2

- LDL < 100
- LDL 100 - 129
- LDL ≥ 130
- No data - no LDL-C
- Not reported

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Done | Internet

Start | Physician Dashboard ... | 2:46 PM

missing lab test

critical value

in compliance with guideline

out of compliance with guideline

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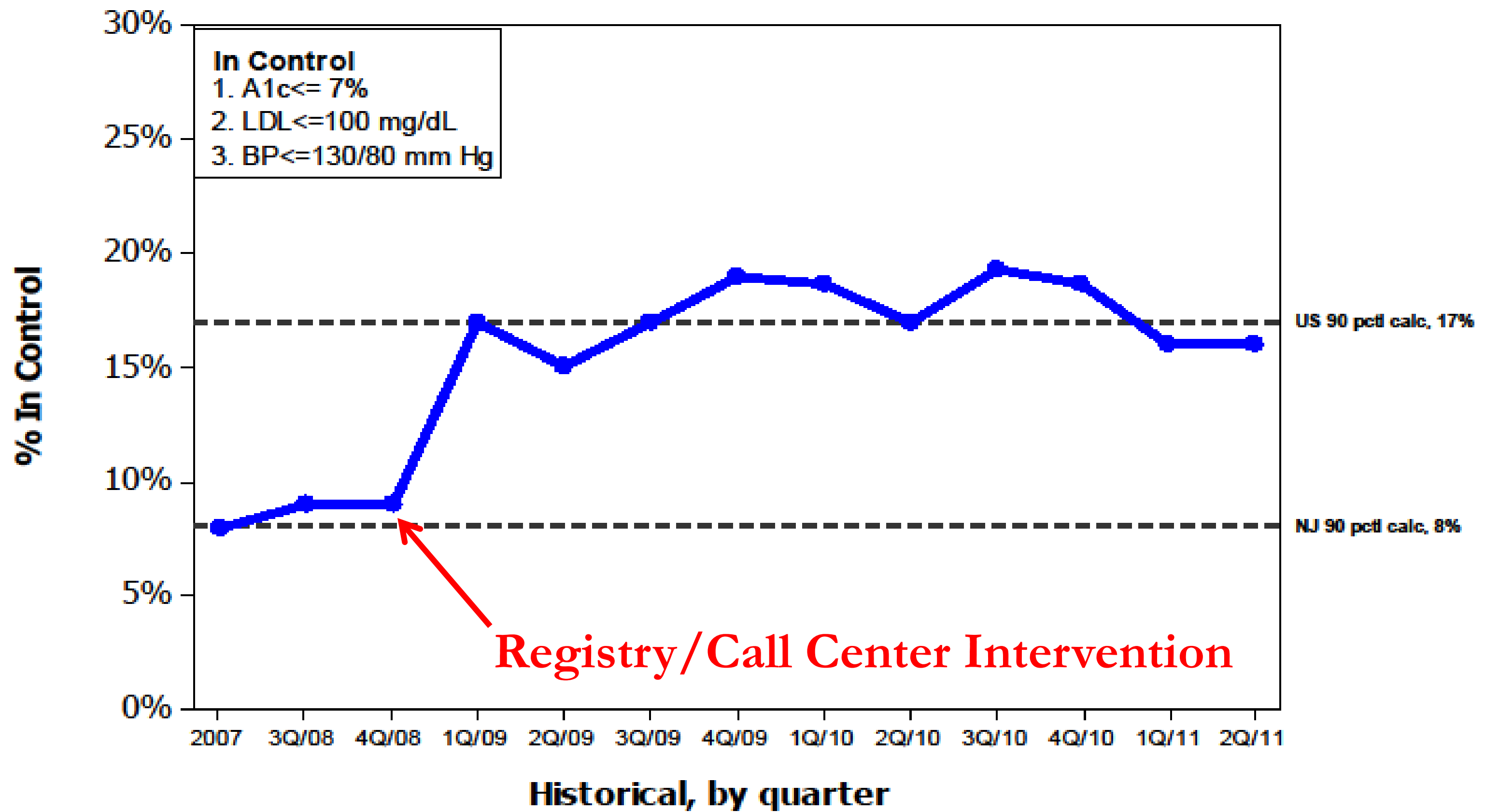

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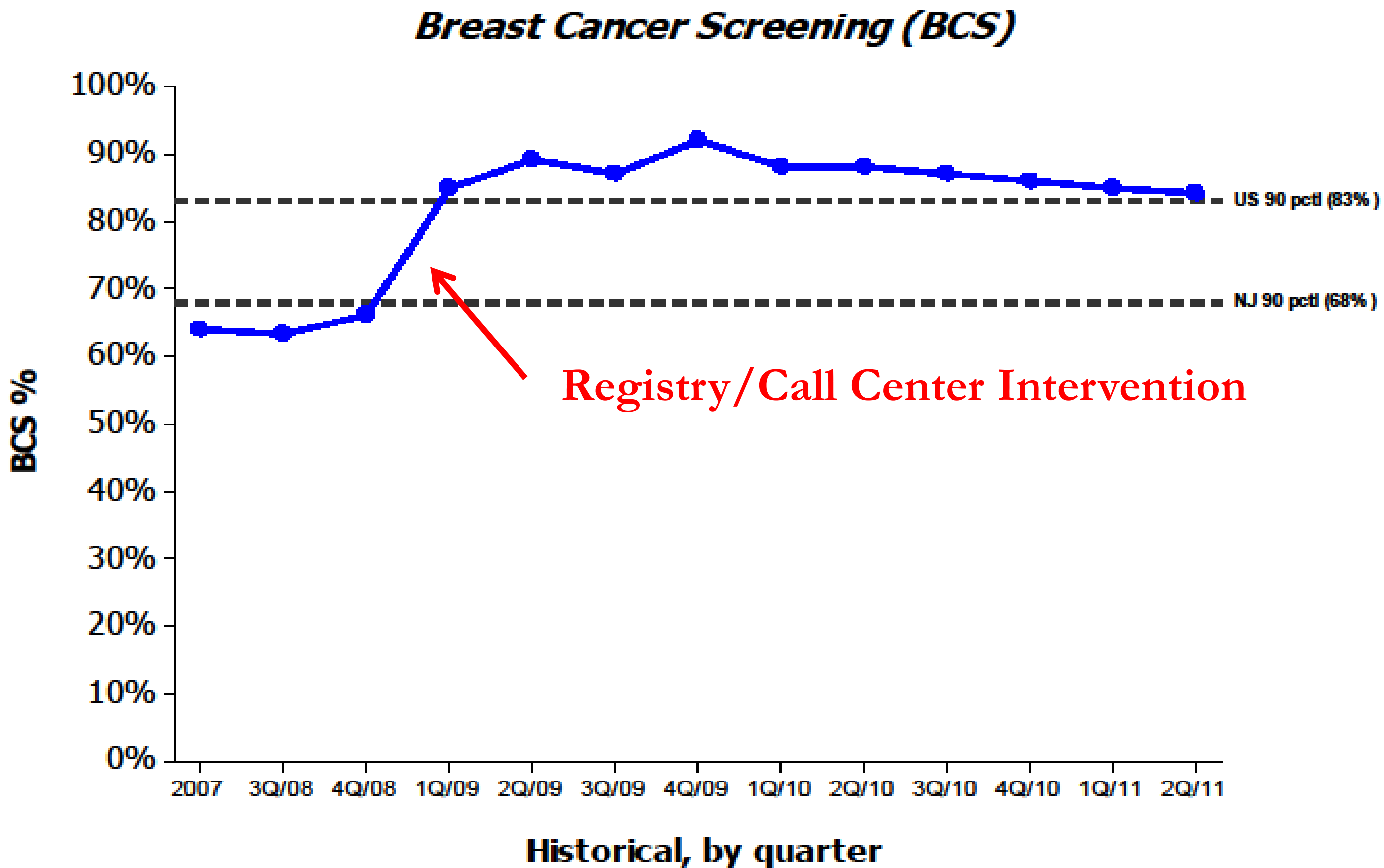
Same technique is successful improving other quality outcomes !



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Challenges

- Data Exchange with Payers
- Proving Short-Term Value of Care Management
- EHR Optimization and Training
- Physician Fear of Loss of Control
- Shared Responsibility for Quality Metric Outcomes

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Future Directions

- Understanding Best Practices
- Care Transformation Center Research
- Readiness for Value-Based Payments
- Coding Education to Improve Risk Scores
- Workflows to Support Billing for Transitional Care Management

SUMMIT MEDICAL GROUP

QUESTIONS?