Mobilizing Team-Based Care to get Results.

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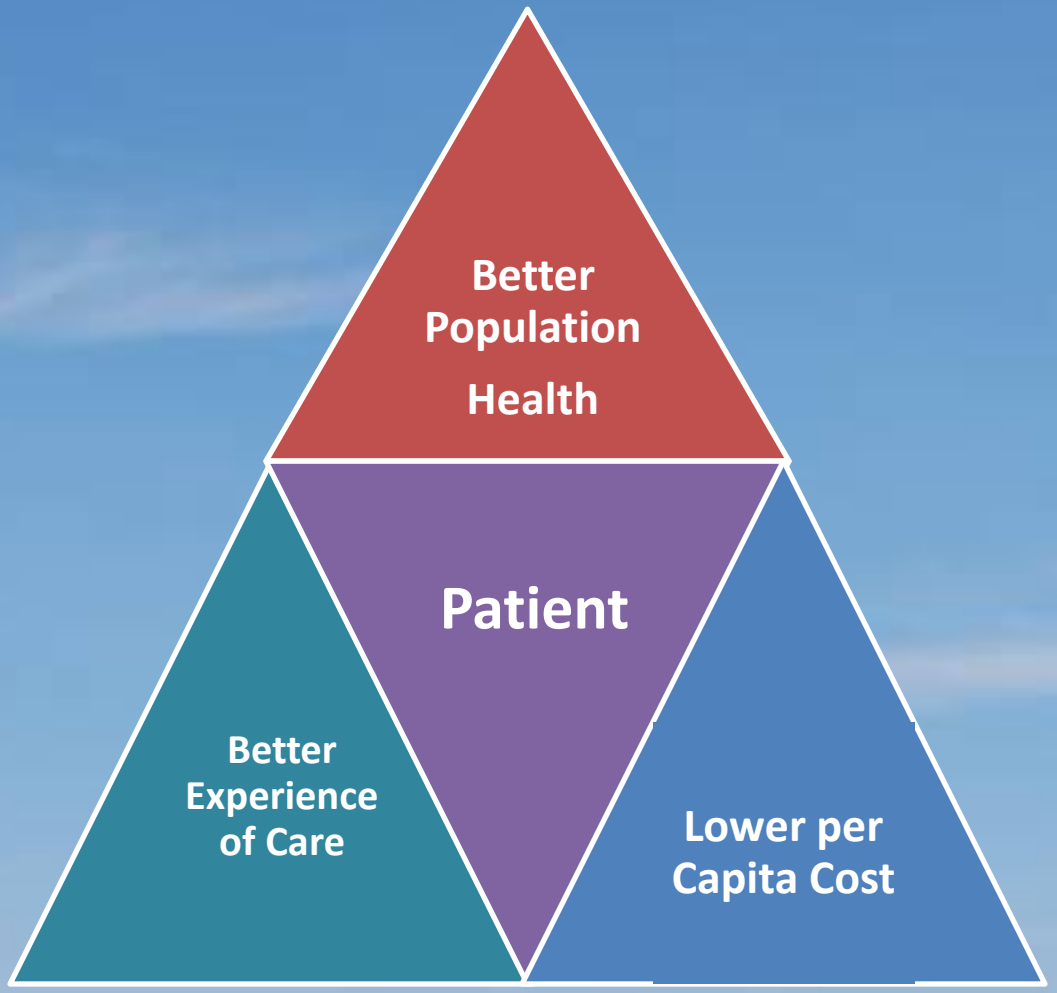
Learning Objectives

Effective ways to mobilize clinical teams towards patient engagement in managing chronic conditions and improving the health outcomes for the population.

Population Health Defined

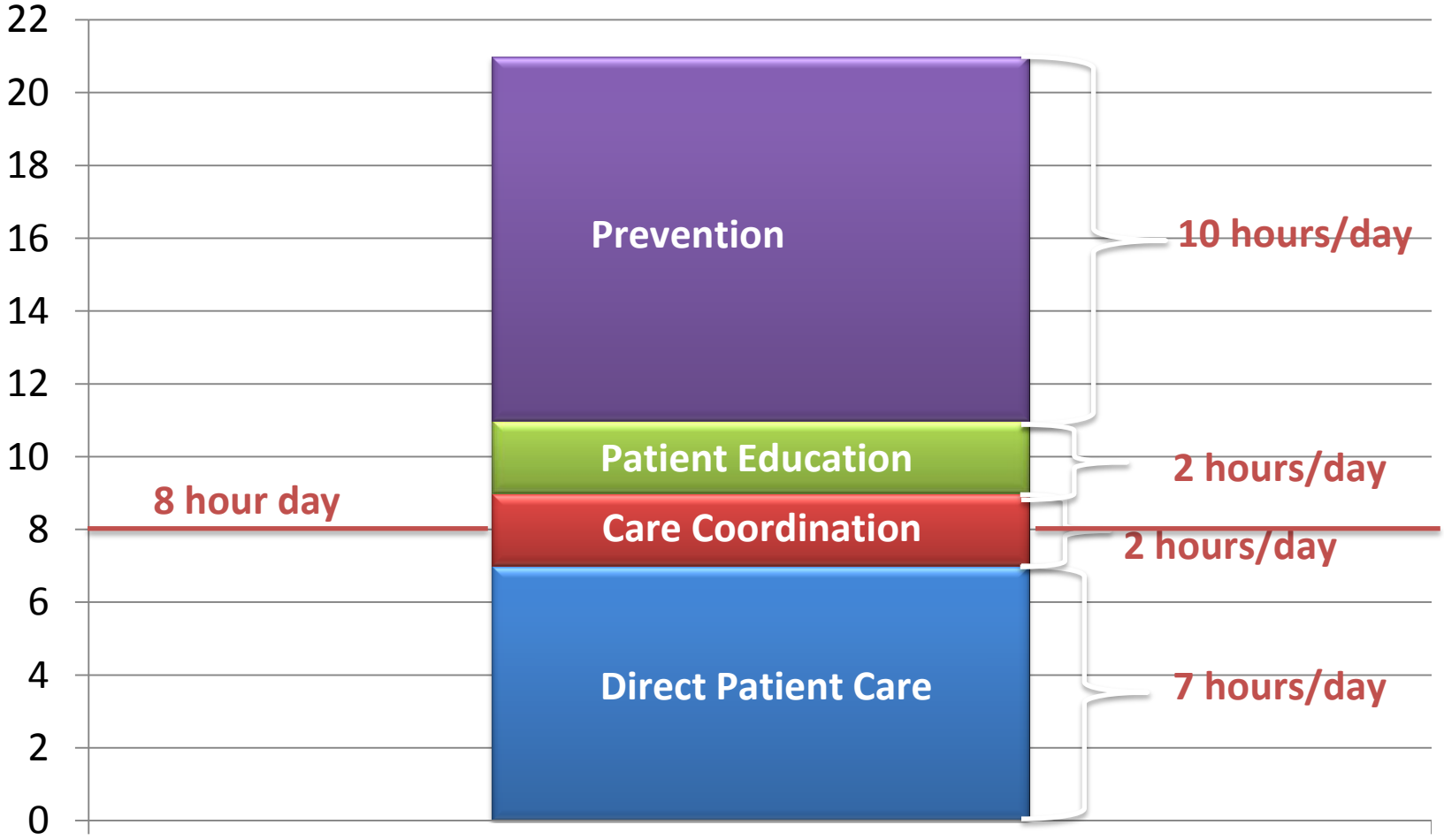
Why use a team to manage population health?

Better Care : Better Health: Lower Cost



Fee for Service		Value Based Care/Accountable Care
		
20 minute visit 22 patients a day Unknown health risks Episodic care		Panel Management Health Risk assessment Quality care Preventive care Total cost of care Patient experience

Delivering safe care is virtually impossible without a team and a system



PCP Physician day
(Based on a panel size of 2000 patients)

Yarnell et al, Primary care: is there enough time for prevention, Am J Public Health 2003; 93:635-41
Bodenheimer, T., "Coordinating Care – A Perilous Journey through the Health care system", NEJM; 358:10, p1064, 2008

“Practice Improvements often fail because they rely on the willingness of physicians, who are already too busy, to take on additional work.”

--- Dr. Tom Bodenheimer

What are we trying to achieve?

Population Health

High Cost ≠ High Risk next year

>2/3

catastrophic patients this year were not catastrophic the previous year

How do you address this in a large multispecialty medical group with …

200,000 assigned patients

1.2 million visits

445 Physicians

60 NP/PA

2000 Clinic staff

21 Clinic locations

Place of Service

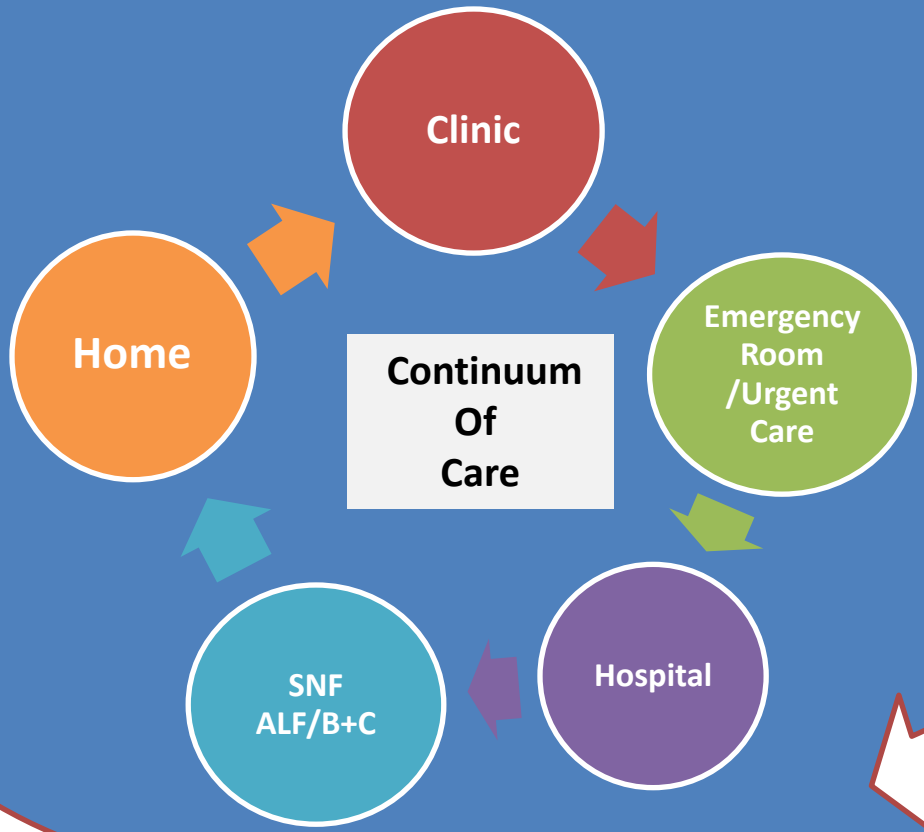
Team Based Care
- ✓ Disease m/m programs
- ✓ Healthier Living
- ✓ Chronic Care Nursing with PCP
- ✓ Complex Case m/m
- ✓ Pharmacy Programs

Transitions (Palliative care)

UC Collaboration Education

Hospital CM
Hospitalist
COC post discharge calls

Extended Care Team
Case Manager
Home Health



Market Dynamics
Sharp ACO Collaborations

Aetna®	Anthem Blue Cross	Center for Medicare & Medicaid INNOVATION
• Commercial PPO Patients • SCMG and Sharp Rees-Stealy Medical Group ("SRSMG")	• Commercial PPO Patients • SCMG and Sharp Rees-Stealy Medical Group ("SRSMG")	• Pioneer ACO • Medicare Fee-for-Service Beneficiaries • Sharp HealthCare, SCMG, SRSMG

Population Health

How to get there?

Important Components

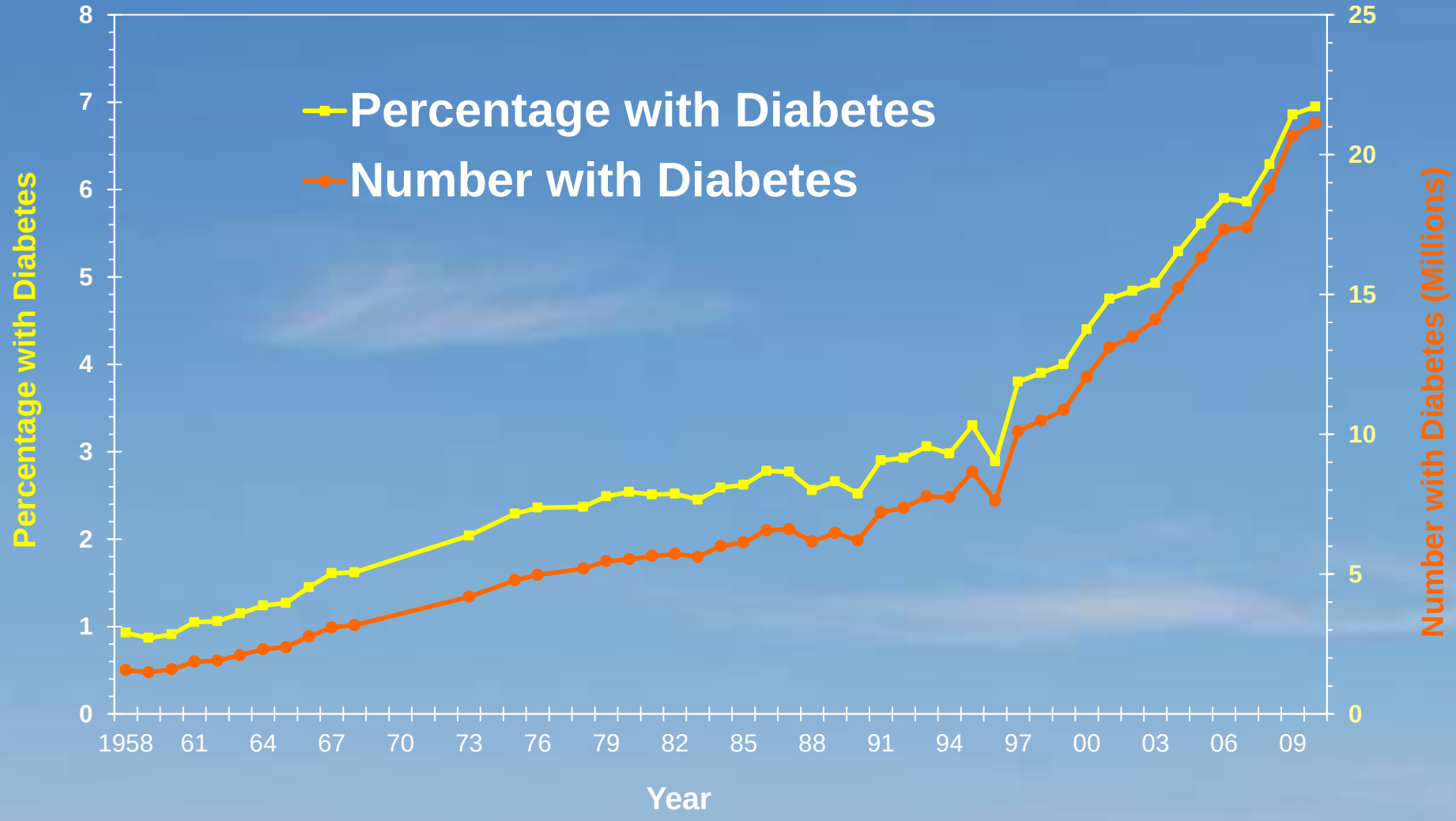
Align Stakeholders

Quiz #1. What is the average prevalence of Diabetes in US?

1. 2% of population
2. 8% of population
3. 20% of population
4. 30% of population

Source : 2009 www.caldaibetes.org last accessed Jan 8 2014

U.S. Population with Diagnosed Diabetes, 1958–2010



CDC's Division of Diabetes Translation. National Diabetes Surveillance System available at http://www.cdc.gov/diabetes/statistics

Quiz #2. What is the total annual cost of healthcare for an individual with Diabetes?

1. $ 5000
2. $10,000
3. $14,000
4. $25,000

Diabetes Rates in San Diego

- About 8% of Central, South, East San Diegans have Diabetes
- Around 28% have Hypertension

18,000 Sharp Rees-Stealy members have been diagnosed with Diabetes

Total Annual Cost of Diabetes Care

$13,700 per member per year

….of which about $7,900 is attributed to diabetes.

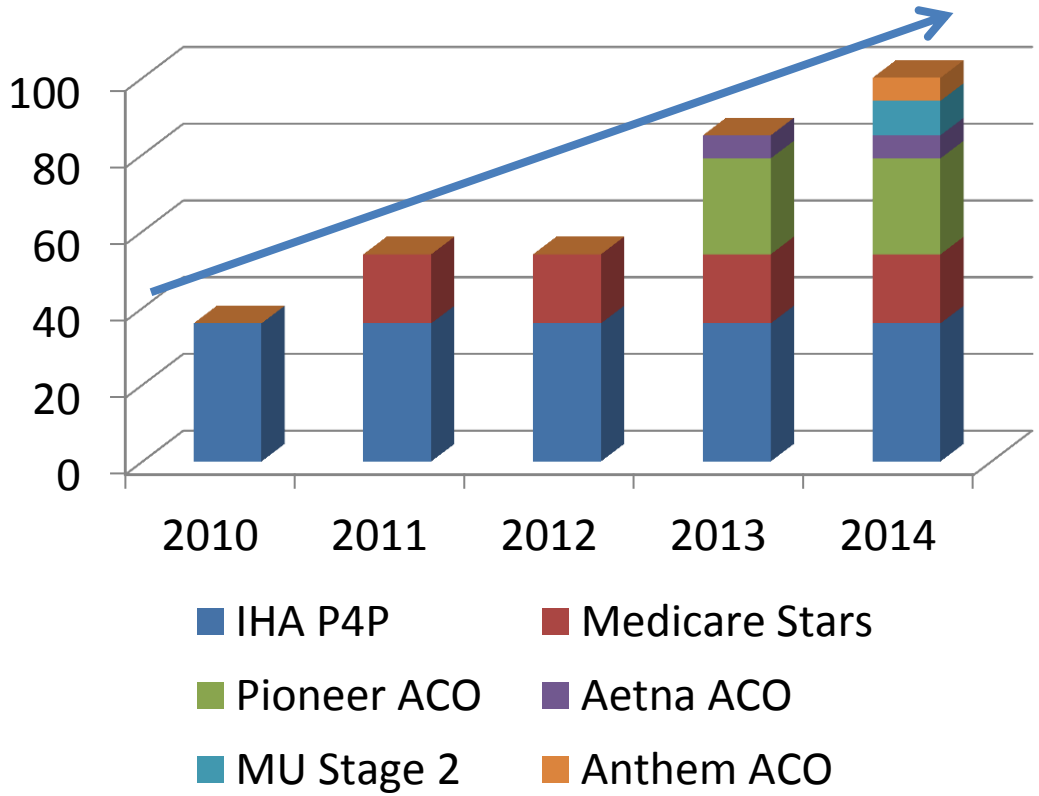
- Hospital inpatient care: **43%** of the total medical cost
- Prescription medications to treat complications of diabetes: **18%**
- Anti-diabetic agents and diabetes supplies:**12%**
- Physician office visits: **9%**
- Nursing/residential facility stays: **8%**

Source: Diabetes Care Vol. 36 March 6 2013 American Diabetes Association

190,000 Population

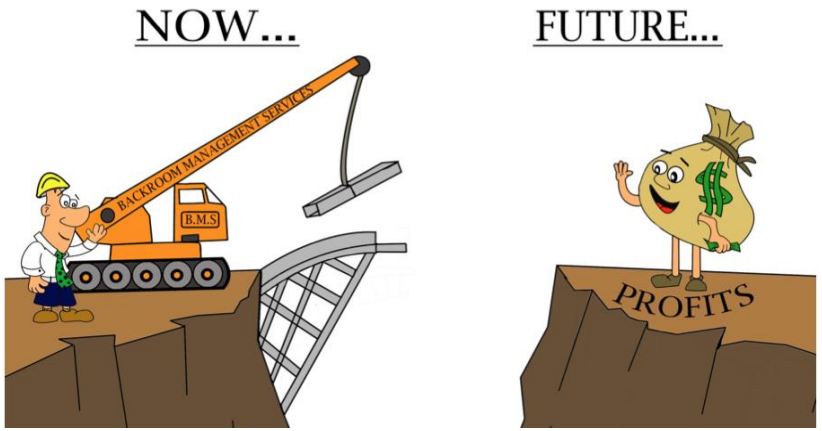
Population
Health
Better Health

Sharp Rees-Stealy reports on around **100** Quality Measures per year



Align stakeholders | Workflows | Team based | Patient engagement | Technology | Physician engagement | Effectiveness

No reform without payment reform



Value based payment models

CMMI

- ACO Shared Saving
- Pioneer ACO

Commercial ACO

Capitation/Global / VBP P4P

FQHC Medical Home payment models

Entity Goal on the Scorecard

‘Population health measures’ are on the Sharp Rees-Stealy entity’s ‘**Balanced Score Card**’

Annual stretch goals are set

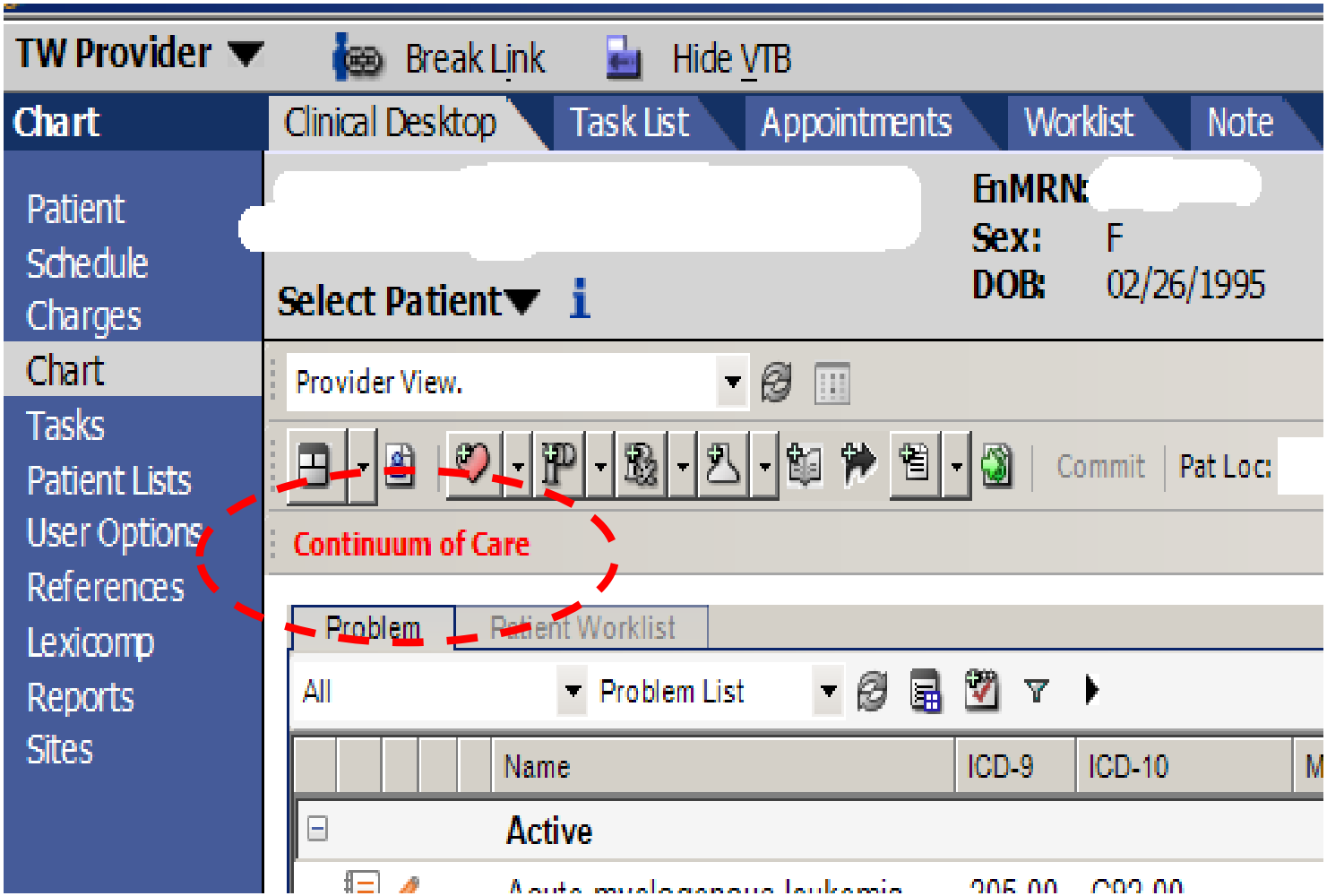
Design a Care Model
2020 Care Model

Clinical Redesign	Physician & Staff	Patient Activation & Shared Decision Making
Care Management Programs • Population Health • Disease Management • Chronic Care Nurses • Complex Case Management Pharmacy Refill Clinic Leveraging Technology Office Standardization	Communication Training On-Stage Leadership	• Health Education Classes • Community Resources • Healthier Living Classes • Patient Representatives on Committees

Align stakeholders | Workflows | Team based | Patient engagement | Technology | Physician engagement | Effectiveness

Have common EHR platform

How to find us in Touchwork?



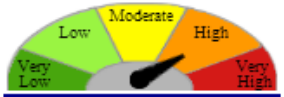
Population Risk Stratification tool

Show More ▼▼▼

Last PCP Visit: 06/05/2012 **Last Ambulatory E/M Visit:** 06/05/2012 **No. of Ambulatory E/M Visits in Last 12 Months:** 1

Patient Summary

Prospective Risk Level



Pred Cost	Patient	Org
Concurrent	$24,825	$2,887
Prospective	$18,858	$2,887

All Medical model

Risk Scores	
Demog Prosp Risk Score	1.98
Concurrent Risk Score	8.60
Prospective Risk Score	6.53
Predictive Risk Score	12.24
LOH-Top 2%	Yes
HCC-Top 1%	Yes
Prospective Risk Cat	High

DCG Medical Conditions
Nutritional and Metabolic
Other Significant Endocrine and Metabolic Disorders
Adrenal gland disorders e.g., Cushing's syndrome
Other Endocrine/Metabolic/Nutritional Disorders
Other unspecified/unclassified endocrine disorders
Gastrointestinal
Other Chronic Gastrointestinal Disorders

DCG Therapeutic Classes
Analgesics/anti-inflammatories
Narcotic analgesics
Anti-infectives
Anti-infectives (oral)
Cardiovascular
Calcium channel blocking agents
Genitourinary agents

Expense & Utilization	2011	YTD 2012
Overall	$5,056.18	$45,135.85
Inpatient		$42,816.86
Outpatient	$2,887.23	$507.20
Rx	$2,168.95	$1,811.79
Imaging	$603.31	$283.17
Acute Admits		1
Total Days (Acute Admits)		4

Dischg Date	Admissions (Clinical Category/Facility)		LOS	Readmit (30d)
01/15/2012	Orthopedics	Facility 1392065	4	No

Date	ER Visits (Primary Dx/Facility)		Admitted	LANE

Gaps in Care	Last Event Date	Last Outcome	Due Date
HEDIS Adult BMI Assessment 2013			
Adult BMI assessment			03/31/2012

Last Fill Date	Current Medications	Qty	Days	Generic
06/29/2012	LISINOPRIL 10 MG TABLET	30	30	Yes
06/27/2012	VERAPAMIL ER 240 MG CAPSULE	60	30	Yes
06/15/2012	PREDNISONE 5 MG TABLET	30	30	Yes
06/15/2012	VESICARE 10 MG TABLET	30	30	No
06/11/2012	HYDROMORPHONE 4 MG TABLET	120	7	Yes
05/17/2012	LORAZEPAM 1 MG TABLET	60	30	Yes

Population Health Risk Stratification Interventions

COMPLEX

Tier 4

5%

Chronic Diseases with two hospitalizations;
needs co-ordination of care.
Reducing avoidable Hospitalization

TIER 3

15%

Programs for Chronic Diseases.

Implementation of evidence based guidelines.

TIER 2

MODERATE SEVERITY

20%

Walking well; need periodic screening tests

Preventive Care Reminder Program

Annual wellness exam and targeted outreach

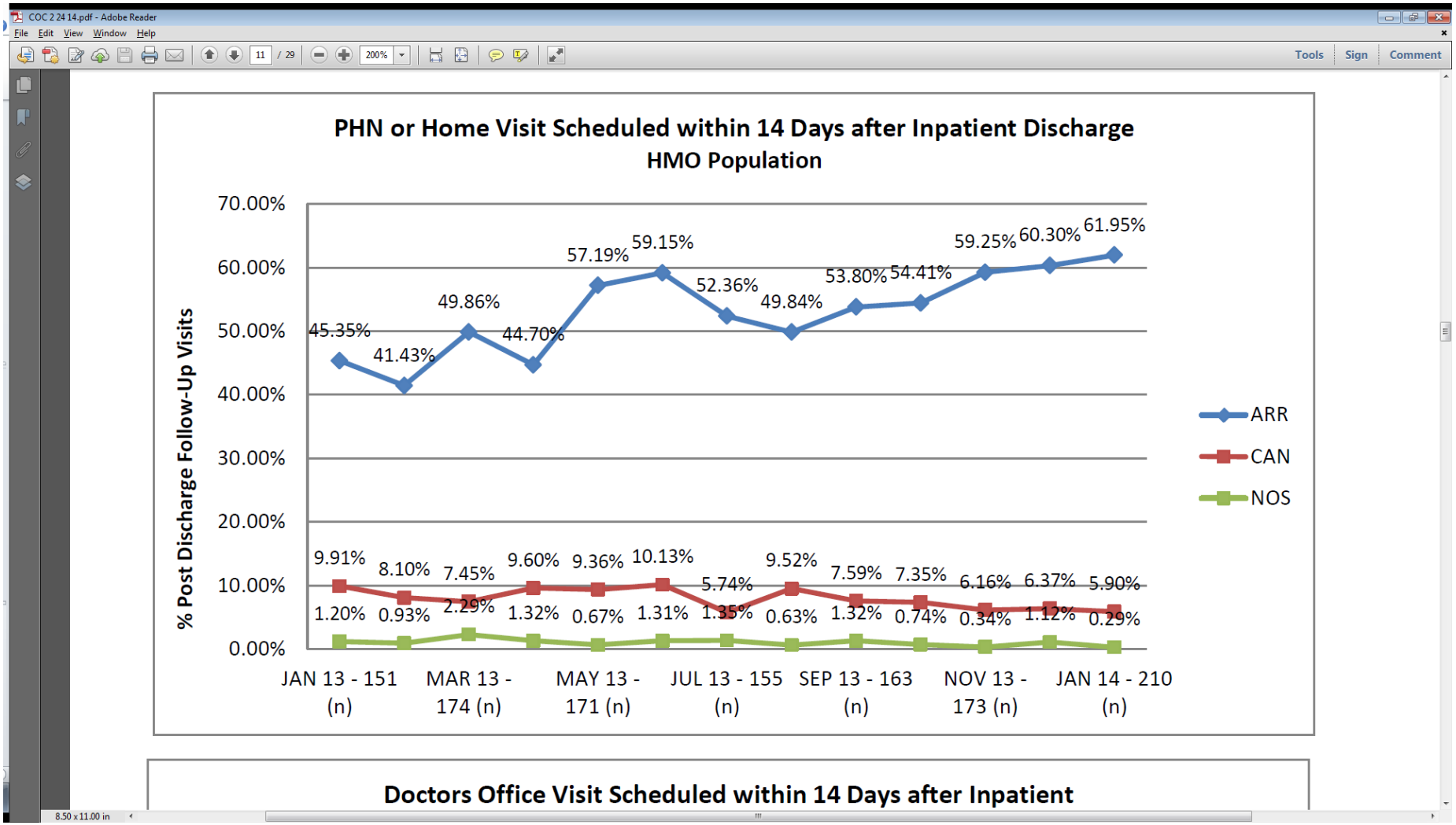
TIER 1

LOW SEVERITY

60%

Keep Patients Healthy, Happy and at Home

Create Workflows with Automation



Align stakeholders | **Workflows** | Team based | Patient engagement | Technology | Physician engagement | Effectiveness

Create Workflows with Standardization

Chronic Care Nursing PHN Checklist

Before the Patient Visit

Touchworks

- ☐ Review last PCP note
- ☐ Review last Specialist note
- ☐ Review immunizations (Flu, PNA, Zoster)
- ☐ Review problem list
- ☐ Review Advanced Directives
- ☐ Review recent labs (If labs ordered but not completed, remind pt to go to the lab ASAP)
- ☐ Review medication list

Cerner

- ☐ Review discharge note
- ☐ Review labs
- ☐ Review discharge medications
- ☐ Review past ER/Hospital admissions records

CCN

- ☐ Compare Cerner and Touchworks medications list. If different, reconcile and notify the PCP

Teamwork
Who is on your team?

Roles of Continuum of Care Teams

Hospital and SNF Case Management	• Hospital and SNF discharge planning • Coordination of care to reduce readmissions
Complex Case Management	• Catastrophic or high risk cases eg. Organ Transplant, MVA , Multiple Comorbidities, UM, Discharge Plan
Chronic Care Nursing	• Team work with PCP, Embedded model • Post hospital and coordinate care of high risk multiple chronic condition patients (short term)
Disease Management	• Long term engagement and management • CHF, COPD,CAD, Asthma, Diabetes
Pharmacy Program	• Medication therapy management • (High cost, Refill, Adherence, High risk, Reconciliation)
Healthier Living	• Group classes and peer support group • Example Chronic Diseases, Obesity

200,000 patients
60 FTE working at top of the license

TRIAGE NURSE

COMPLEX
Care at Home

NP, Social Worker, Case Manager RN

Multiple Chronic Conditions
need co-ordination of care
Reducing avoidable Hospitalization

Case Manager RN, Chronic Care RN

Programs for Chronic Diseases
Reaching goals as per evidence based guidelines for chronic disease
Diabetes, Asthma, CHF, COPD, Obesity, HTN

Disease Manager level 2 & 3, Pharmacist

Walking well; need periodic screening tests
Preventive Care Reminder Program

Care Coordinator
Diabetic Educator
Health Coach
Pharmacy Tech

Align stakeholders | Workflows | Team based | Patient engagement | Technology | Physician engagement | Effectiveness

Care Team Staff Ratio

RN SUPERVISOR	1:15-20 CARE MANAGERS
RN TRIAGE	1:500 REFERRALS/MONTH
RN CASE MANAGER LEVEL 3	1:125-150 MEMBERS
RN CASE MANAGER LEVEL 2	1:195-250 MEMBERS
POPULATION HEALTH CASE MANAGER	1:250-500 MEMBERS
RN CASE MANAGER TELEHEALTH	1:500-1000 MEMBERS
MSW	1:125-150 MEMBERS
MA	1:500 MEMBERS
COMMUNITY HEALTH WORKER	1:100 MEMBERS
ADMINISTRATIVE SUPPORT	1:5 RN DMS, 750-1000 MEMBERS

SHARP Rees-Stealy Medical Centers

Optimize Care Team Roles

Level III

Level II

Level I

Disease Management Activity Report

Case Load by Status

Dates Covered: Between 2/20/2014 and 3/6/2014

	FTE	Goal Meritted Case Load	Current Referred (n)	Referred (+/-)	Current Enrolled (n)	Enrolled (+/-)	Total Engaged (n)	Engaged (+/-)	ACE Question Completion Rate (%)	ARB Question Completion Rate (%)
	1.0	100=2 110=3 130=4	2	-17	0	-	134	+5	92%	92%
	1.0	100=2 110=3 130=4	14	-2	7	-	157	-15	67%	67%
	1.0	100=2 110=3 130=4	28	+11	0	-	138	+1	53%	53%
	1.0	100=2 110=3 130=4	41	+25	0	-	134	+4	88%	75%
	1.0	100=2 110=3 130=4	37	+17	0	-	115	-3	100%	100%
	1.0	100=2 110=3 130=4	21	-19	0	-	84	+3	-	85%
	1.0	150=2 165=3 195=4	41	+8	5	-11	131	-6	-	-

Align stakeholders | Workflows | Team based | Patient engagement | Technology | Physician engagement | Effectiveness

Teamwork

Case Managers
Social Worker
Disease Managers
Care Specialists
Clinic Staff
Pharmacist/Pharmacy Tech
Health Coach

OK. Now you have a team.
But how effective are they?

Quiz #3: One effective way to engage patients in self management of their chronic disease is….

1. Make sure to provide all ‘care instructions’ in one session
2. Present yourself as part of Care Team; one who works with your PCP/office staff
3. Provide generic education material
4. My way or the highway

Engage the Patient

Partner with me

Form personal connection

Face to face interaction

Step by step wellness plan

Coordination of care across the system

Patient specific education material

Shared care plans

Medication adherence reporting

Use HIT to engage all patients not just present

Patient Driven Care

Patients largely produce their own outcomes!

"The needs of the patient come first."

"Nothing about me without me."

"Every patient is the only patient."

Quiz #4. For more efficient management of patient population…

1. Patient's 'risk score' looking at predictors of cost is sufficient by itself.
2. In general, 'all' patients adhere to treatment guidelines after their clinic visits.
3. Patient activation scores provide relevant information beyond the risk score.
4. Activated patients know how to navigate through the system and use more resources and hence incur more cost.

Source: Judith H. Hibbard, Jessica Greene and Valerie Overton *Health Aff February 2013 vol. 32 no. 2 216-222*

Measure the Engagement Rate

Disease Management

Program	LII & LIII Refs	LII & LIII Non-Data Refs	Ref Status	Enr Status	Eng Status	Closed Eng	Closed Non-Eng	Decl	Eng Rate	Prev Month
CAD	392	24	51	637	53	28	115	31	19.47%	19.90%
Asthma	270	12	0	704	86	11	47	7	34.40%	30.75%
Diabetes	1200	215	114	3797	471	49	256	68	36.75%	34.05%
COPD	n/a	159	0	69	55	16	14	5	44.65%	44.72%
CHF	n/a	470	2	104	180	117	48	19	63.49%	63.04%
Overall DM	1862	880	167	5311	845	221	480	130	38.88%	37.21%

Senior Enhanced Care Management

Total Referred	Ref Status	Enr Status	Eng Status	Closed Eng	Closed Non-Eng	Decl	Eng Rate	Prev Month
853	19	0	539	85	30	180	73.15%	73.73%

Align stakeholders | Workflows | Team based | **Patient engagement** | Technology | Physician engagement | Effectiveness

Empowering Towards Self-Management:

Healthier Living Classes

Healthier Living classes 2013 YTD:
15 workshops
118 participants

63% completion rate

Chronic Condition	
Diabetes	38.0%
Asthma	14.1%
Emphysema or COPD	1.4%
Other lung disease	2.8%
Heart disease	22.5%
Arthritis or rheumatic disease	36.6%
Cancer	16.9%
Depression	26.8%
Anxiety disorders	18.3%
Hypertension (high blood pressure)	47.9%
Stroke	2.8%
Osteoporosis (low bone density)	15.5%
Other chronic condition	43.7%
None (no chronic condition)	2.8%

Other chronic conditions reported: spinal surgery, high cholesterol, plantar fasciitis, retinal eye disease, deteriorating lumbar disc, peripheral neuropathy, spinal stenosis, cervical and lumbar spondylitis, facet syndrome, dialysis, degenerative disc disease, back pain, abdominal aneurysm, pain related to brain tumor, migraines, neck pain, lumbar radiculopathy, seizures (graves'), chronic pain, sleep apnea, obesity, trigger finger(s), fibromyalgia, hypothyroid, kidney disease, irritable bowel syndrome, liver cyst, parotid tumor, knee pain, narcolepsy & hemochromatosis

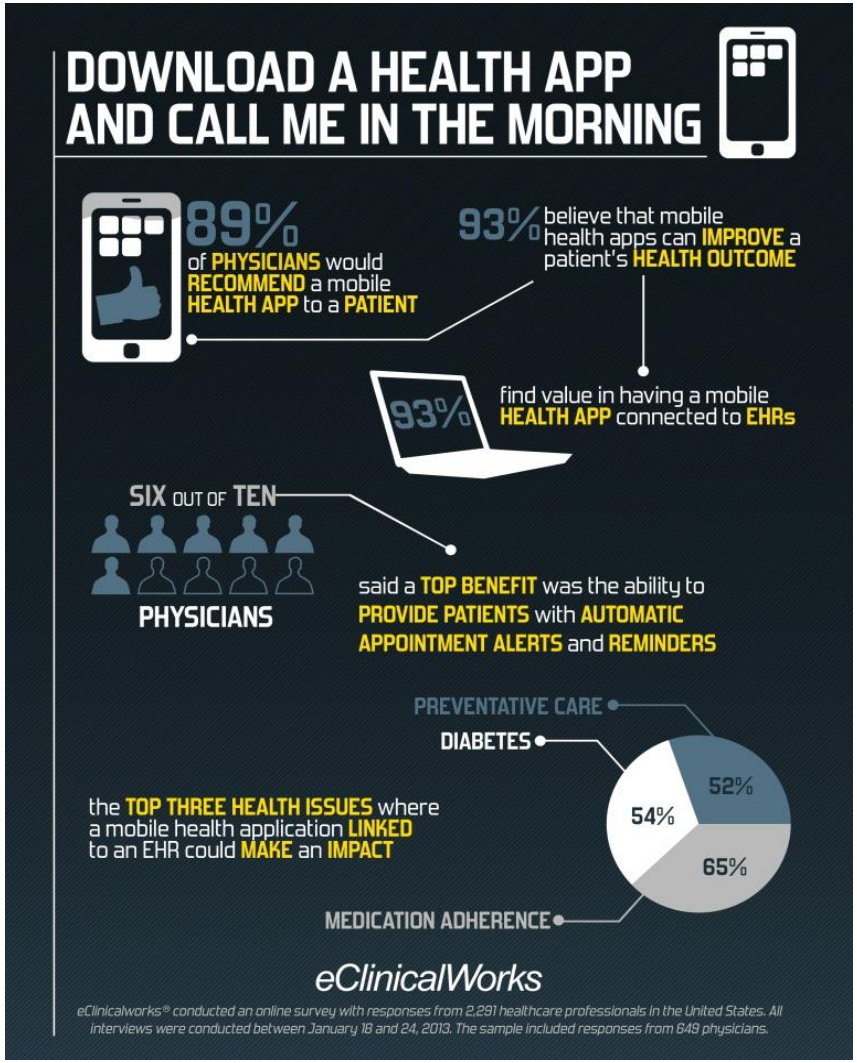
Average # of chronic conditions = 2.9
Participants with 1 chronic condition = 12
Participants with 2-3 chronic conditions = 31
Participants with 4+ chronic conditions = 23

Quiz #5: In a recent survey what percentage of Physicians would recommend a mobile Health App to a patient ?

1. 30% of Physicians
2. 50% of Physicians
3. 80% of Physicians
4. None would recommend

Source: Pricewaterhouse Coopers– HRI Physician Survey, 2010

Devices that Drive Healthier Behavior



…the booming mHealth market will grow to **$26 billion by 2017**, reaching a worldwide market of 1.7 billion users looking to **use their smartphones and tablets to take care of their health**. Currently, there are about 97,000 mobile health applications…

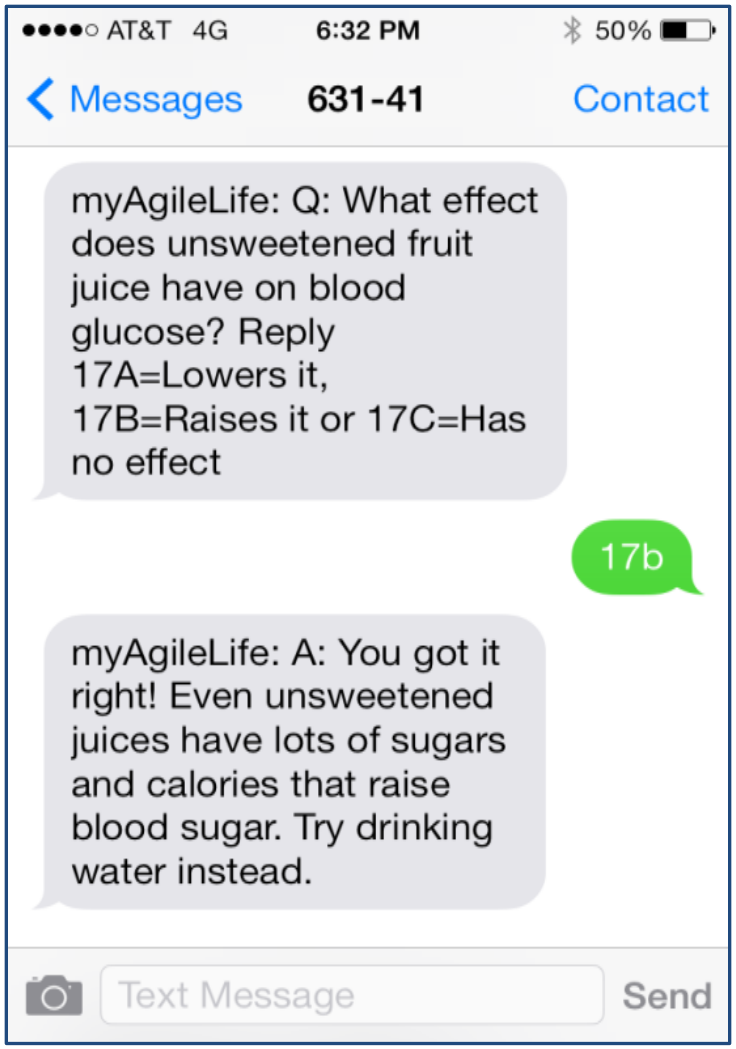
---research 2guidance 2013

88% of physicians want patients to track or monitor their health at home.

---PricewaterhouseCoopers– HRI Physician Survey, 2010

Align stakeholders | Workflows | Team based | Patient engagement | **Technology** | Physician engagement | Effectiveness

Sometimes, people like talking to computers



Propeller Health video

190,000 patients. 60 FTE
Working at top of the license

Triage Nurse

COMPLEX
House calls

NP, Social Worker, Case Manager RN

Multiple Chronic Conditions
Needs co-ordination of care
Reduce avoidable hospitalization

Case Manager RN, Chronic care RN

Cardiocom for CHF

Programs for Chronic Diseases.
Reaching goals as per evidence based guidelines for chronic disease
Diabetes, Asthma, CHF, COPD, Obesity, HTN

Disease Manager level 2 & 3, Pharmacist

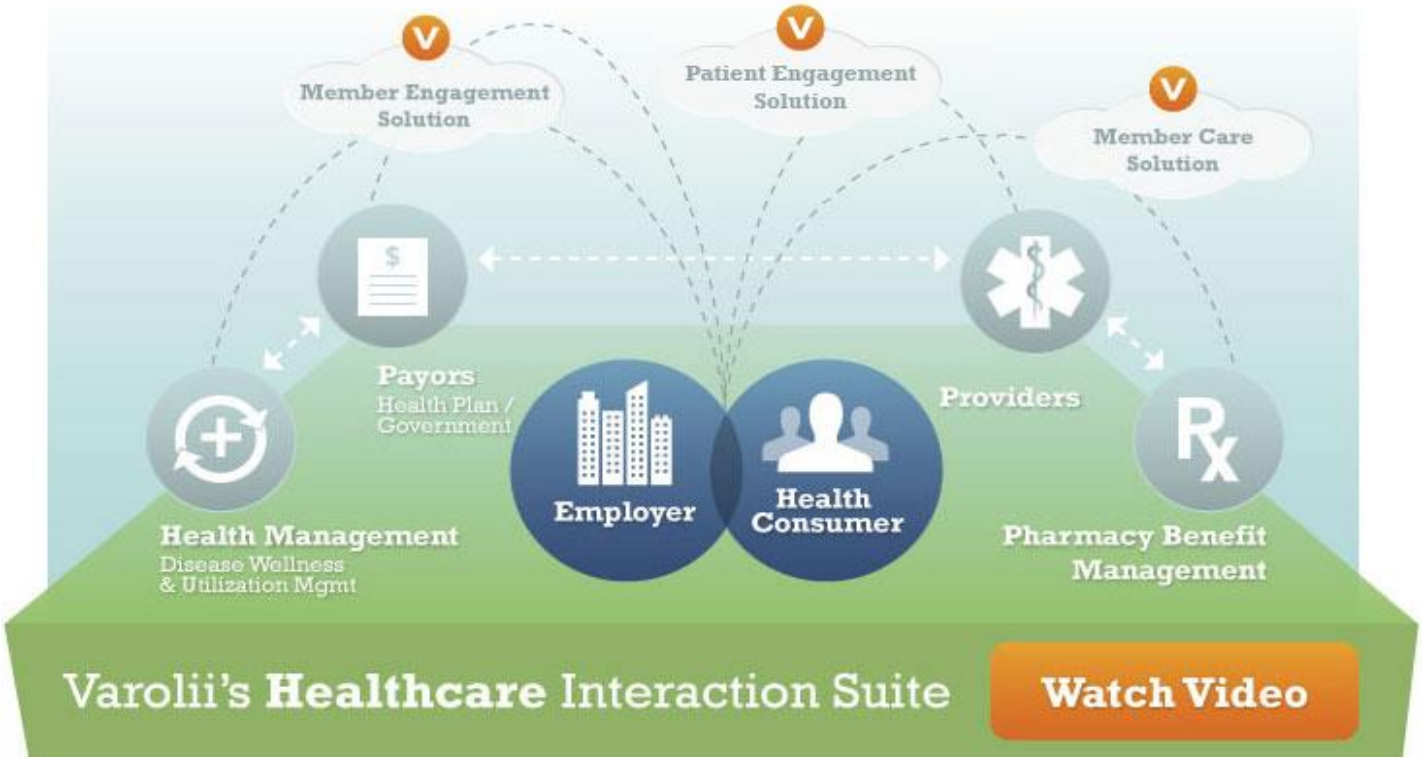
Propeller Health Diabetes Text messaging

Walking well; need periodic screening tests
Preventive Care Reminder Program

Care Coordinator
Diabetic Educator
Health Coach
Pharmacist Tech

Outreach in Multiple Ways

Outreach using MySharp web portal
and Nuance telephonic outreach messages



New motto : Minimize the number of lists which go out to the Doctors and Clinic sites

Quiz #6: What is the most effective way to engage physicians in a quality improvement project?

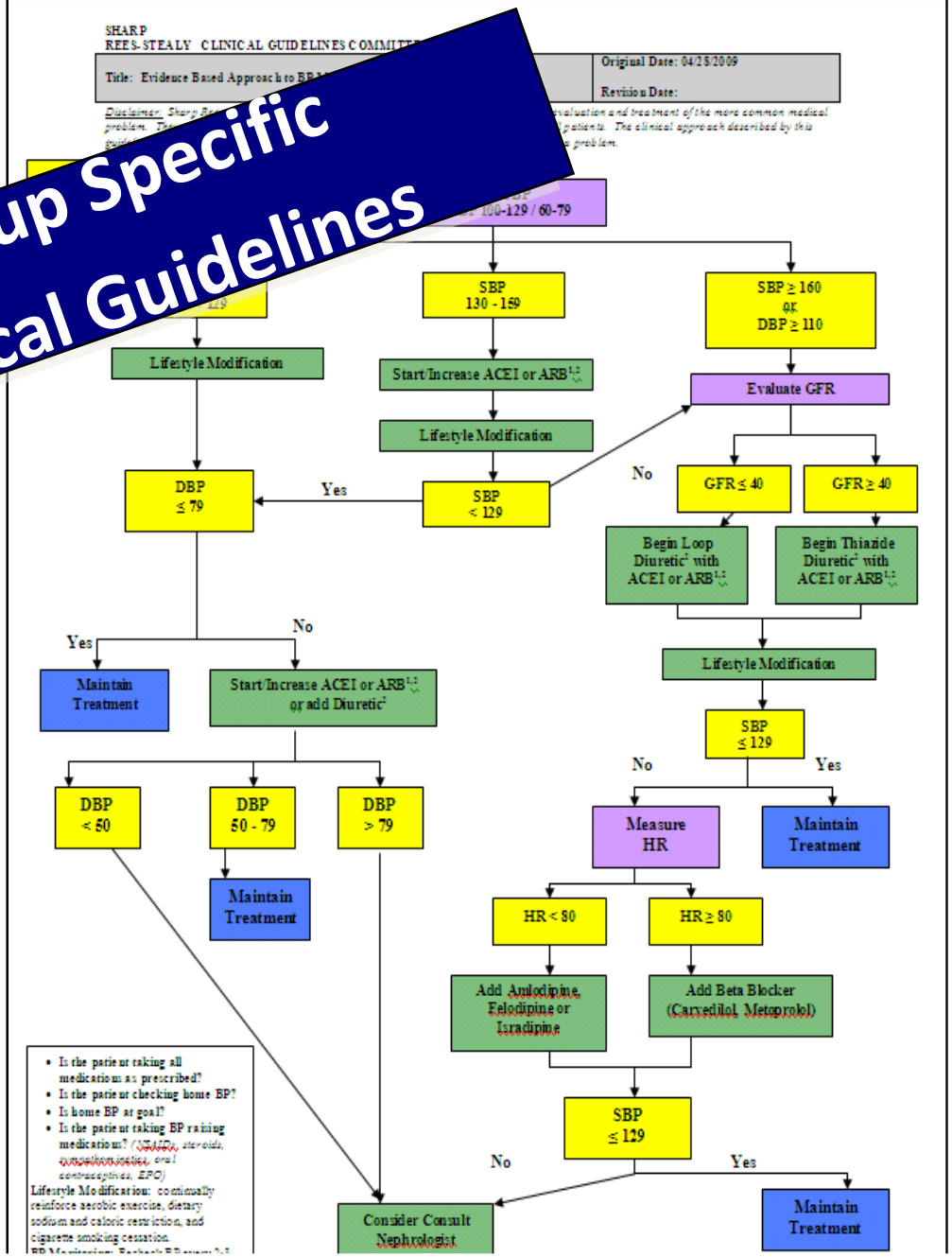
1. Physicians will figure it out on their own.
2. Simple outline on what you want the physicians to do.
3. Hand out copies of Diabetes Association guidelines.
4. Campaign to patients '*Ask your doctor about perfect diabetes care'.*

Physician Engagement Strategy

1. What do you want your Physicians to do?
2. Do they know how to do the work?
3. Do they have the resources to do the work?
4. Are physicians motivated to do the work?

Ralph Jacobson is founder and principal of The Leader's Toolbox and author of "Leading for a Change: How to Master the Five Challenges Faced by Every Leader." He is also a faculty member of the Physician's Leadership College. He can be reached at www.theleaderstoolbox.com .

Group Specific Clinical Guidelines

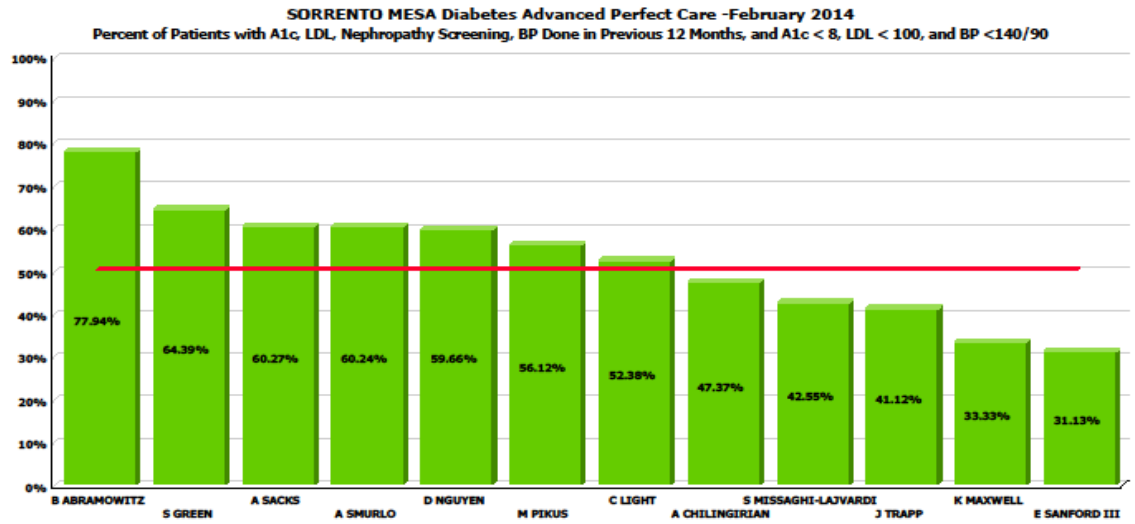


Align stakeholders | Workflows | Team based | Patient engagement | Technology | Physician engagement | Effectiveness

Address Practice Variation

Peer Review

SHARP Rees-Stealy Medical Centers
Monthly Diabetes Graphs



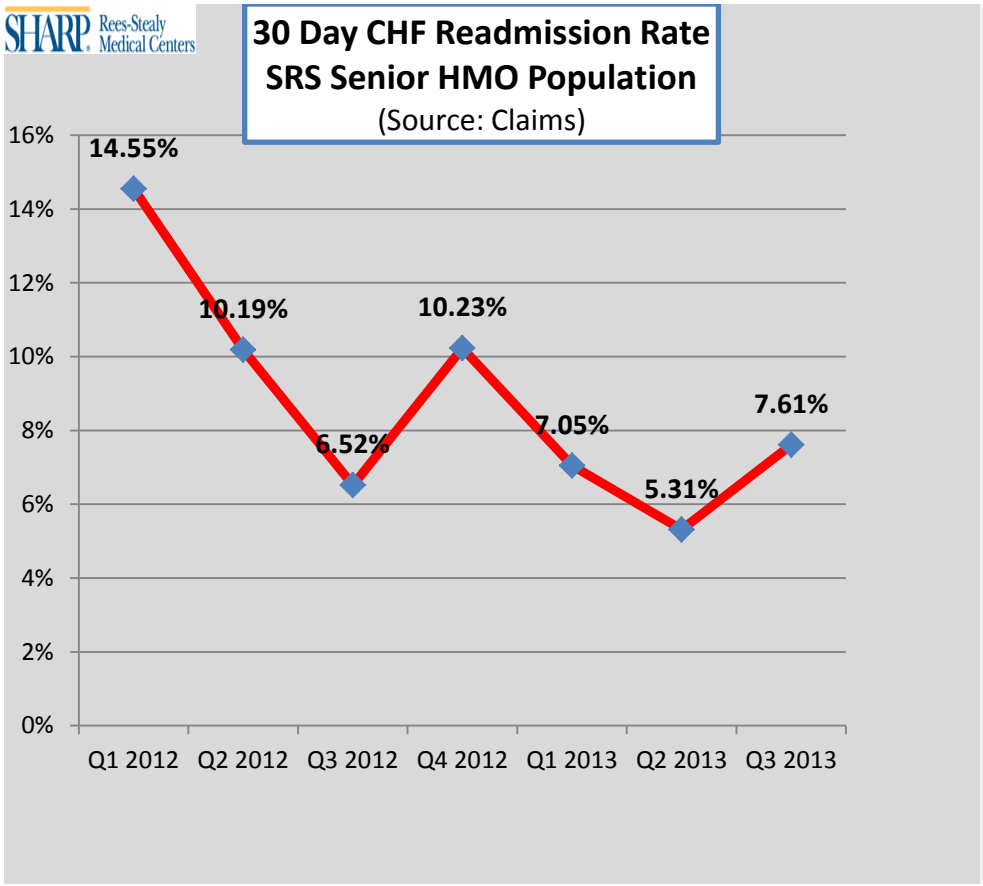
Dr. A Dr. B Dr. C Dr. D Dr. E Dr. F Dr. G Dr. H Dr. I Dr. J Dr. K Dr. L

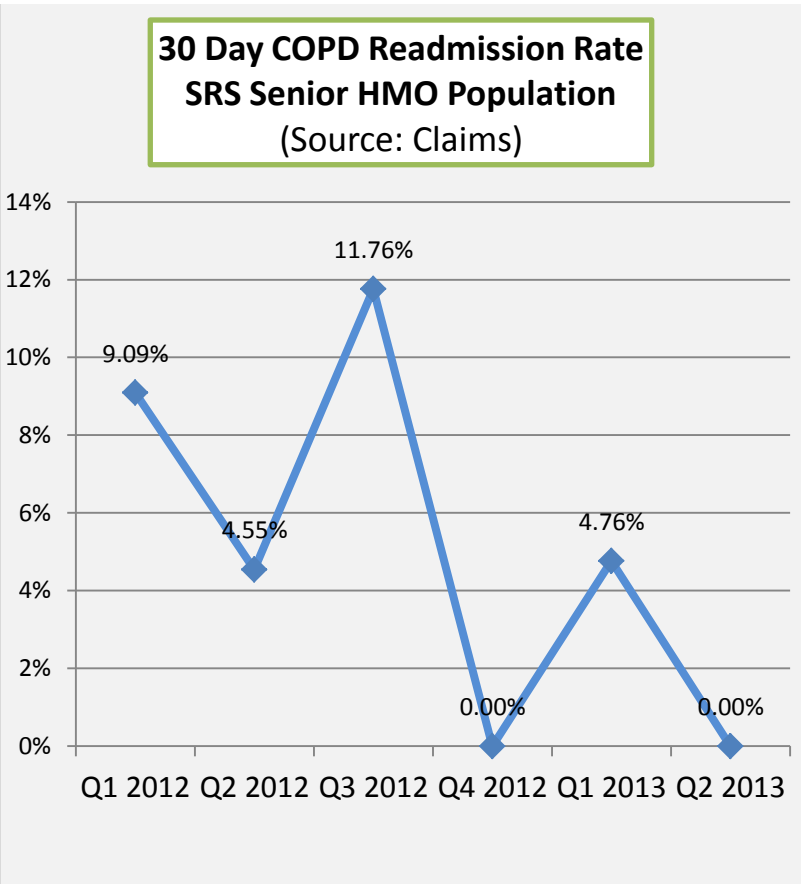
Higher Rate Means Better Control

Number of Patients Advanced Perfect Care

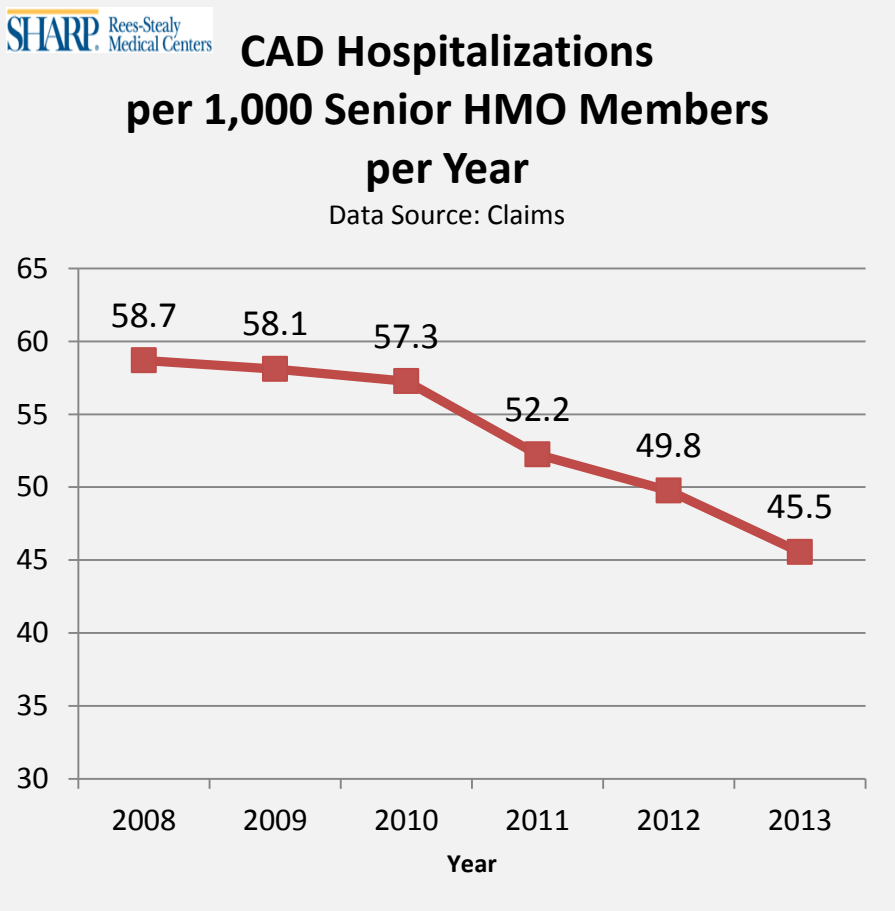
B ABRAMOWITZ	S GREEN	A SACKS	A SMURLO	D NGUYEN	M PIKUS	C LIGHT	A CHILINGIRIAN	S MISSAGHI-LAJVARDI	J TRAPP	K MAXWELL	E SANFORD III

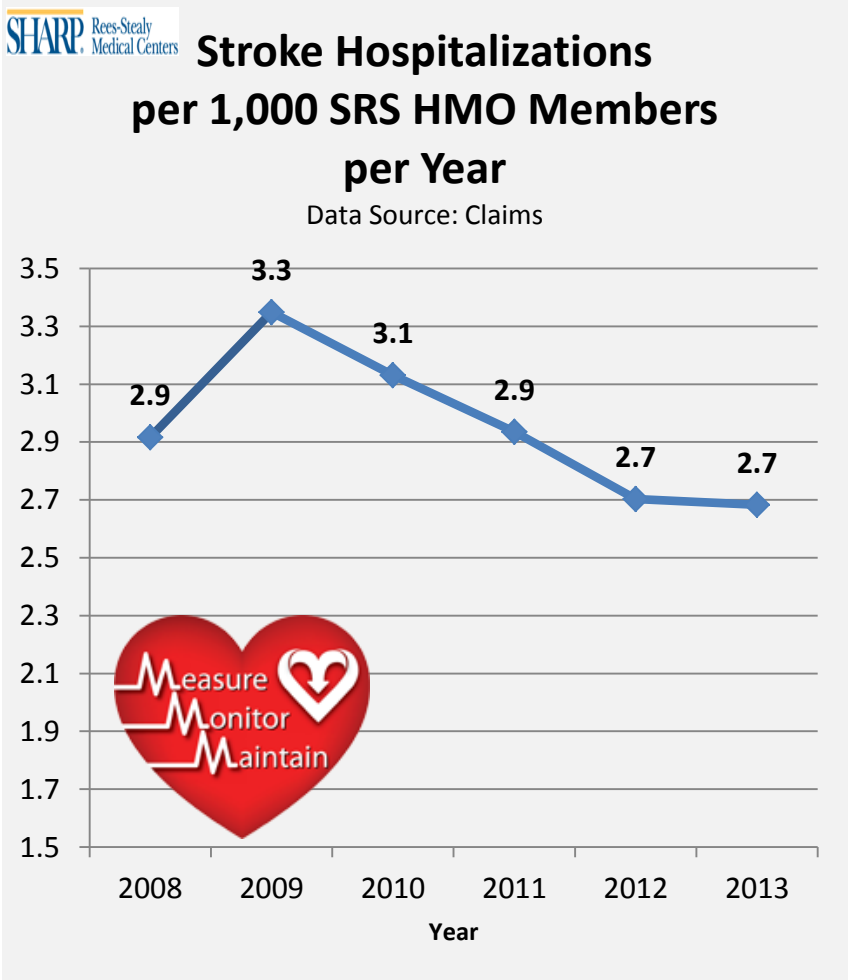
Track Effectiveness





Continuous Improvement Process





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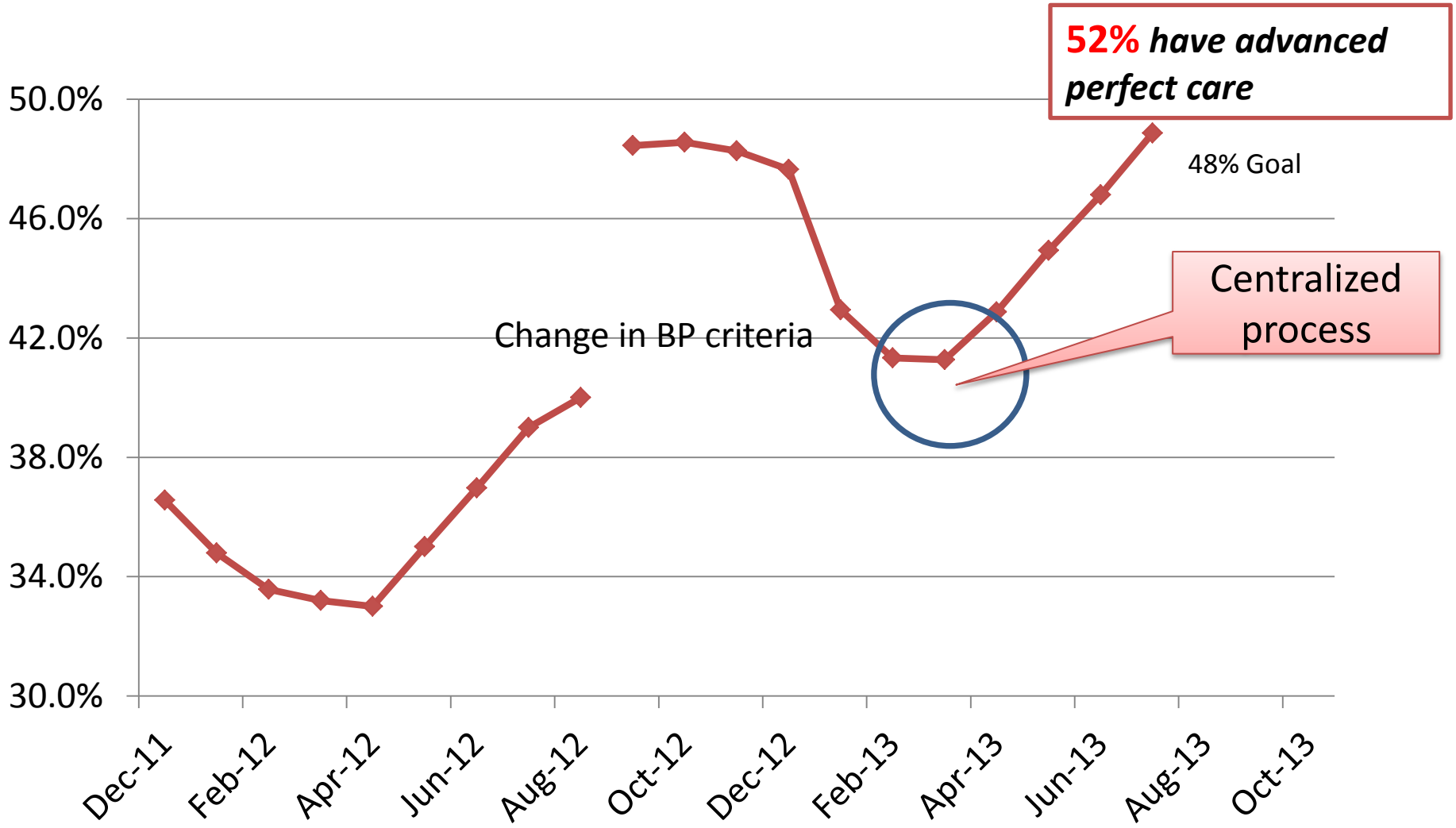
Continuous Improvement Process

'All or none' Diabetes bundled care



Align stakeholders | Workflows | Team based | Patient engagement | Technology | Physician engagement | Effectiveness

Quiz #7: What is the average annual End Stage Renal Disease cost per patient requiring dialysis?

1. $10,000
2. $40,000
3. $70,000
4. Half a million

Source: Kidney disease statistics for the United states National Kidney and Urologic Diseases Information Clearinghouse

Preliminary Improve Clinical Outcomes

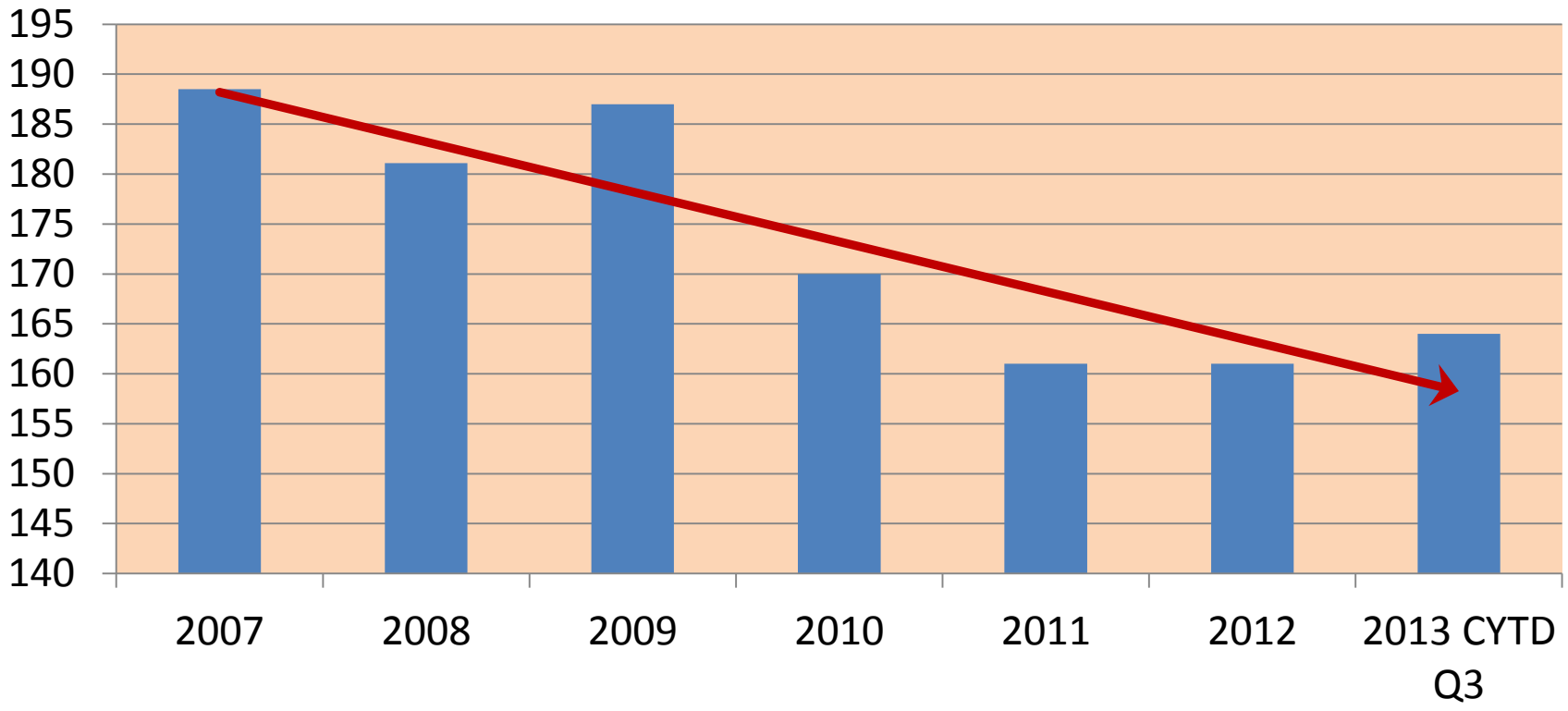
Heart attack , stroke prevention and other associated complications focused on Diabetes patients

Diabetes 'Advance Perfect Care' beneficiaries (n=8543)	Controlled For 6 months (n= 1952) **New** complication /1000 /Yr.	Uncontrolled For 6 months (n=6591) **New** complication /1000/Yr.	Reduction in complication	Annual Cost avoidance
Acute Myocardial Infarction	4.10	4.55	9.9% reduction	$660,000 (22 x$30,000 per episode)
Renal failure requiring dialysis	0	0.46	100% reduction	$210,000 (3 x$70,000 annual per ESRD)
Retinopathy	19.98	22.45	11% reduction	$218,000 (109X $2000 low annual t/t cost per DR)
Stroke	5.64	6.37	11% reduction	$1,240,000 (31 x $40,000 for first 90 days)

Demonstrating ROI
Appropriate Resource Utilization

* there are many external variables which may also affect point usage

PTMTY Points based on Hospital fund services
Relative Value scale



Align stakeholders | Workflows | Team based | Patient engagement | Technology | Physician engagement | Effectiveness

It is all about Teamwork!

“We always hope for the easy fix: the one simple change that will erase a problem in a stroke.

But few things in life work this way. Instead, success requires making a hundred small steps go right - one after the other, no slipups, no goofs, ***everyone pitching in****.”*

-Atul Gawande, Better: A Surgeon’s notes on Performance.

Mobilizing Team Based Care
Population Health
Lessons Learned

Align stakeholders	• Organization scorecard
Patient care workflows	• Keep it simple and centralized
Team based healthcare	• Highest scope of license
Patient Engagement	• Measure
Technology	• Leverage it
Physician Engagement	• Address practice variation
Performance	• Demonstrate the ROI
Change is Hard	• Share best practices

http://www.youtube.com/watch?v=21TL94NEzvg

http://youtu.be/21TL94NEzvg

2007 Malcolm Baldrige National Quality Award

Top 10% Nationally for Patient Satisfaction

The Best Place to Work
The Best Place to Practice Medicine
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Union Tribune San Diego's Best Medical Group

Best Integrated Health Care Network in California, 2010

for Quality and Service - Office of the Patient Advocate 2012 Health Care Quality Report Card

★★★★

American Medical Group Association (AMGA) Acclaim Award Honoree

Integrated Healthcare Association Top Performing Group in CA

California's Top Performing Physician Group

Formerly Milliman Care Guidelines

Elite Status by California Association of Physician Groups

We now welcome your questions….

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