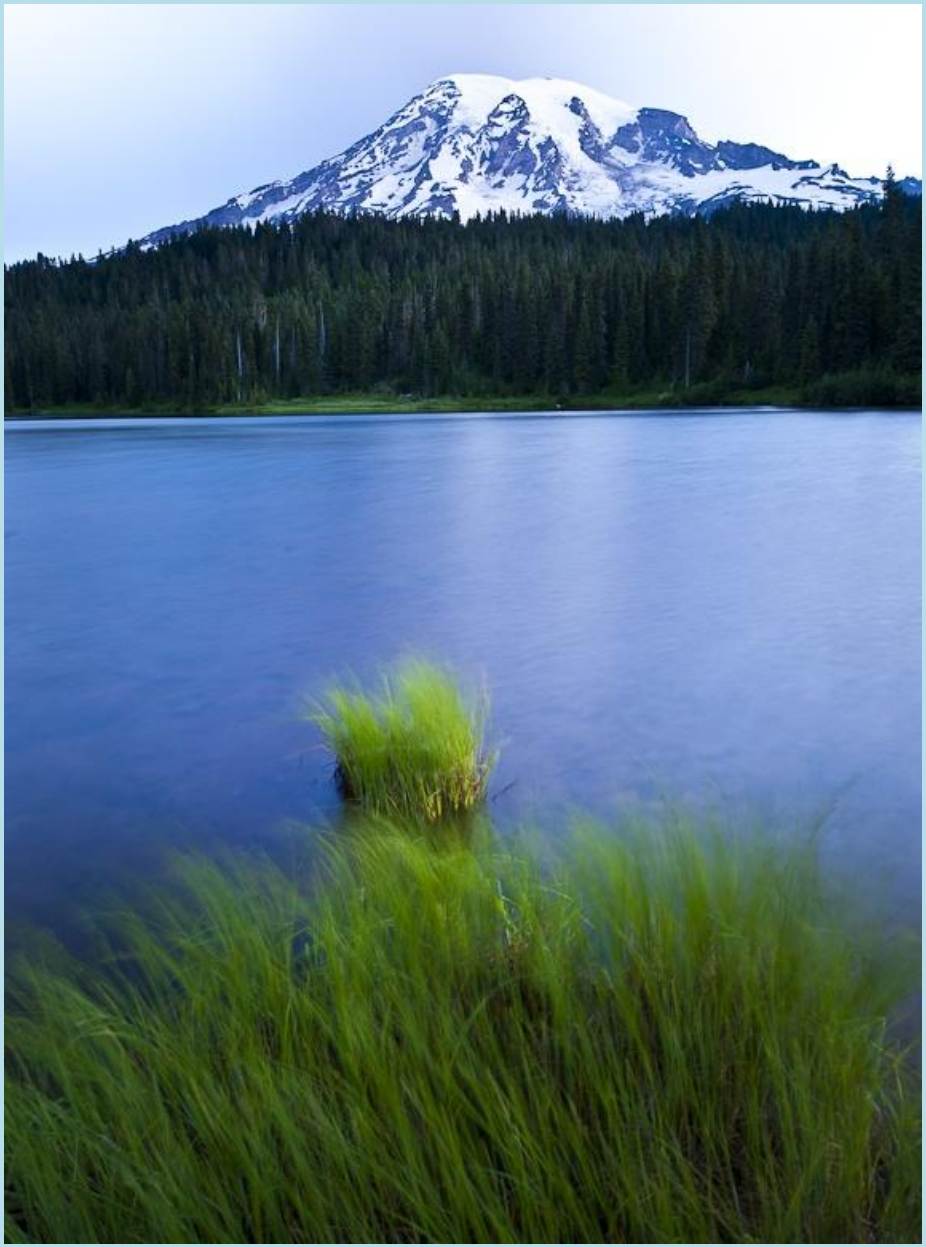
ACO Accelerated Development Learning Session

San Francisco, CA
September 15-16, 2011

Module 3B. Connecting Providers and Managing High-Risk Patients

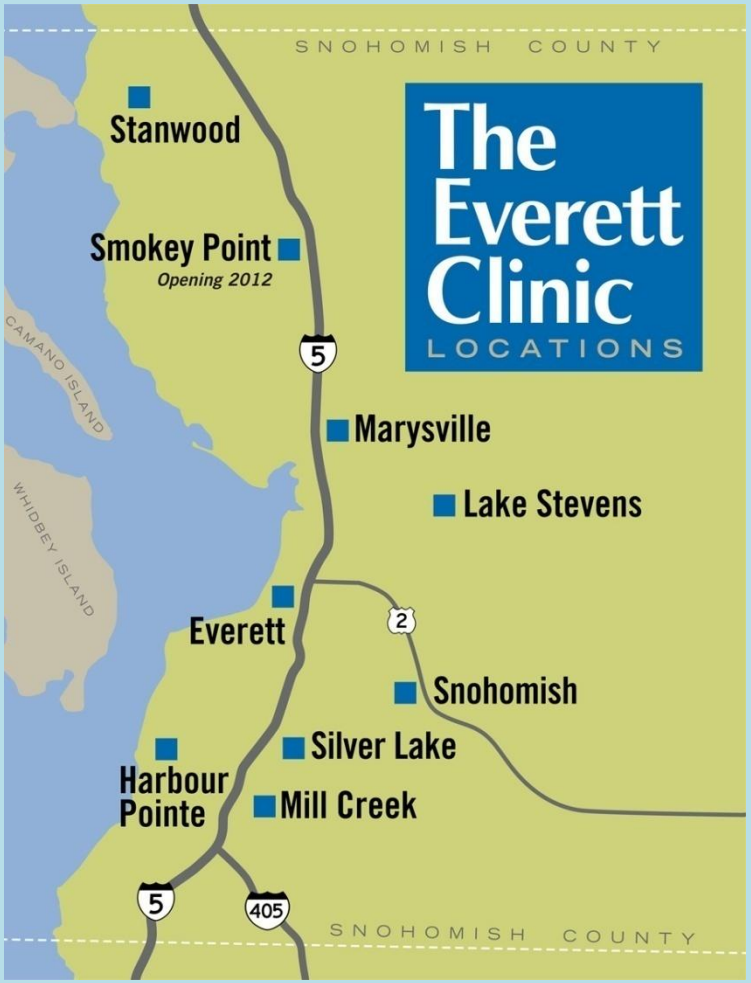
September 16, 2011
8:15–10:15 a.m.

Steve Jacobson, MD
Jennifer Wilson Norton, RPh, MBA
The Everett Clinic



The Everett Clinic (TEC) Overview

- Largest independent medical group (WA)
- 8 satellite locations throughout Snohomish County
  - Smokey Point (opening 2012)
  - 8 walk-in clinics
- 5th largest private employer in Snohomish County
  - 1,700 employees
  - 415 health care providers
    - 315 physicians (45 hospitalists)
    - 100 advanced clinical practitioners



The Everett Clinic

Services:

- More than 40 diverse medical specialties (primary care and specialty services)
- Advanced imaging center
- Two surgery centers
- Regional cancer center
- Three regional pharmacies

Patients:

- 295,000 active patients
  - 850,000 visits annually
  - 25,000 surgeries annually
  - 41,000 Medicare patients

Our Culture

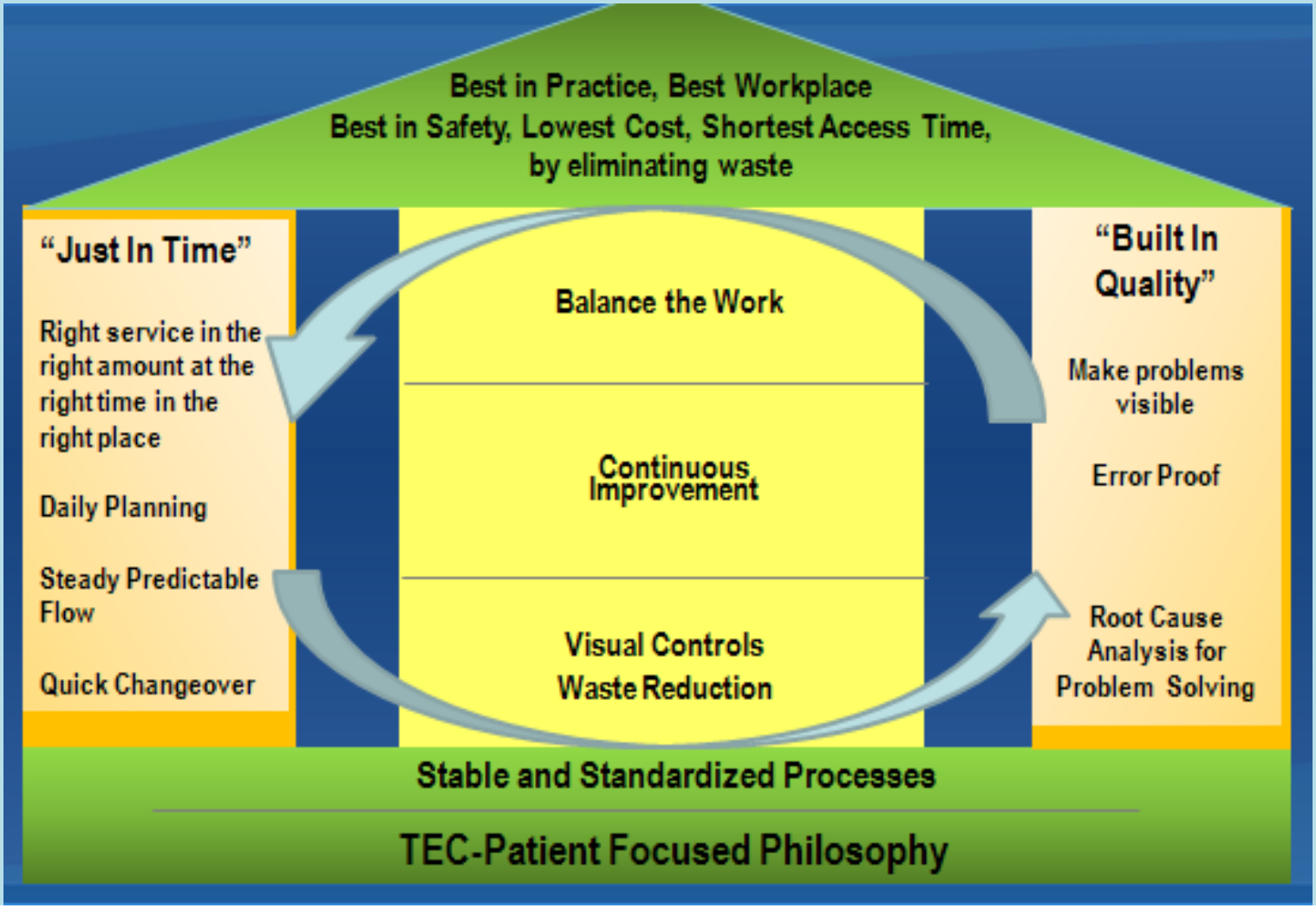
- Practice evidenced-based medicine
- And, evidence-based leadership
- Patient centered
- Treat people with courtesy and respect
- Listen to staff
- Offer flexibility
- Culture of excellence and innovation
- Use Lean principles
- Integrated technology
- Recognition and rewards

And we like to have fun!

Our Core Values

- We do what is right for each patient
- We provide an enriching and supportive workplace
- Our team focuses on value: service, quality, and cost

TEC Management and Improvement System



1912

The 'Great Divide'

"...for the first time in human history, a random patient with a random disease consulting a doctor chosen at random stands a better than 50/50 chance of benefitting from the encounter."

~Harvard Professor L. Henderson

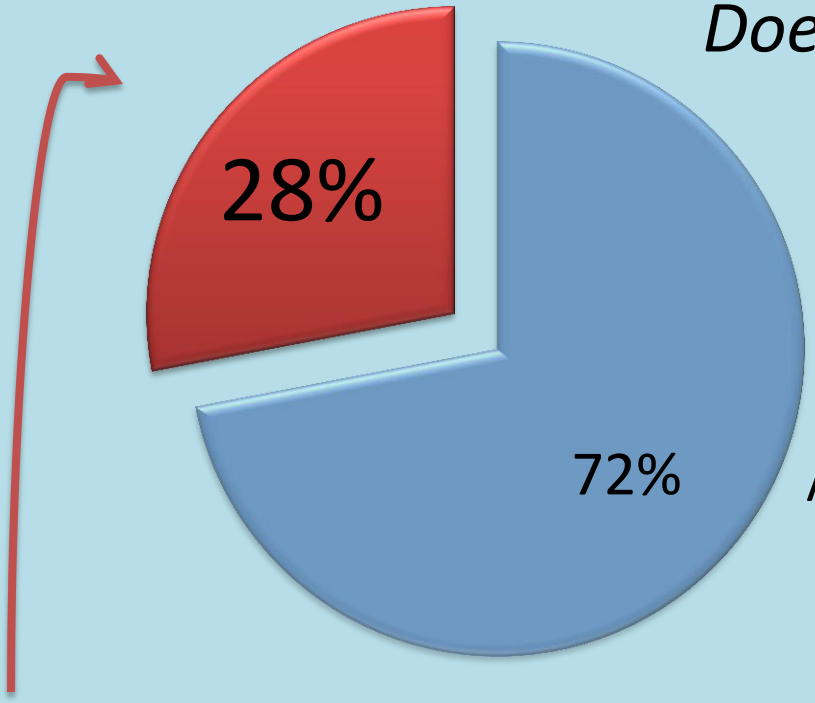
(Harris, Richard. A Sacred Trust. New York, NY: New American Library, 1966)

ACO Pitfalls

- Overestimating organizational ability to
  - Manage risk
  - **Use electronic health records**
  - **Report performance measures**
  - **Implement standardized care management protocols**
- Failure to balance interests and engage stakeholders
  - Hospitals, primary care providers, specialists
  - Governance and management processes
  - Patients and families
  - Contractual relationships with the most cost-effective specialists
  - Laws and regulations
- **Failure to recognize interdependencies and integrate beyond structural level**

Singer, S. & Shortell, S. "Implementing Accountable Care Organizations: Ten Potential Mistakes and How to Learn From Them." JAMA. August 9, 2011. http://jama.ama-assn.org/content/early/2011/08/05/jama.2011.1180.extract

Spending



Does this make sense?

All other years of life

Percent of Medicare spending on recipients' final year of life

DATA:
Medicare Payment Advisory Commission
Article: "USA, Inc." Bloomberg Businessweek.
Feb 28 – Mar 6, 2011.

Learning Objectives

- Utilize different health plan and data techniques to identify complex patients
- Review The Everett Clinic's key care management programs, results, and lessons learned
- Gain an increased understanding of how organizations can utilize their electronic health records (EHR) and other electronic tools to manage complex patients

Our Journey in Managing Complex Populations

- Identifying the complex patient
- CMS PGP P4P Demonstration Program
- Boeing IOCP Pilot Program
- Partners in Palliative Care
- Advanced Care Coordination
- Transition Management
- EHR and Other Electronic Systems and Tools

Identifying Complex Populations

- Prospective models provide greater ability to focus care and resources
- Models used to date
  - Health plan predictive modeling
  - Higher utilizers of hospital-based services
  - Review of readmissions
  - Team referral at discharge or other key interfaces

CMS Medicare P4P Demo Program

- 5-year project – ended April 1, 2010
- 9,000 Medicare Fee for Service patients (TEC)
- 32 quality improvement metrics
- Must achieve >2% points in total cost savings compared to the local trend line
- Savings shared annually between CMS and providers based on quality performance

CMS PGP Demo Quality Metrics

Diabetes Mellitus	Congestive Heart Failure	Coronary Artery Disease	Hypertension & Cancer Screening
HbA1c Management	LVEF Assessment	Antiplatelet Therapy	Blood Pressure Screening
HbA1c Control	*LVEF Testing*	Drug Therapy for Lowering LDL Cholesterol	Blood Pressure Control
Blood Pressure Management	Weight Measurement	Blood Pressure	Blood Pressure Plan of Care
Lipid Measurement	Blood Pressure Screening	*Lipid Profile*	*Breast Cancer Screening*
LDL Cholesterol Level	Patient Education	LDL Cholesterol Level	Colorectal Cancer Screening
Urine Protein Testing	Beta-Blocker Therapy	Antiplatelet Therapy	Blood Pressure Screening
Eye Exam	Ace Inhibitor Therapy	Ace Inhibitor Therapy	
Foot Exam	Warfarin Therapy		
Influenza Vaccination	Influenza Vaccination		
Pneumonia Vaccination	Pneumonia Vaccination		

CMS PGP Demo Results

- TEC has improved the quality of care and moderated (slightly) the cost trend line
- Total gain sharing with TEC ~ $250,000
- Cost to TEC ~ $500,000 annually
- We have been rewarded with tremendous learning opportunities

Key Learnings from PGP Demo

- Disease management: Diabetes, congestive heart failure, coronary artery disease, hypertension anchored in EHR
- Preventive care
- Palliative care
- Hospital coach: Seamless communication during care transition
- Post hospitalization visits <= 5 days
- Importance of diagnostic coding

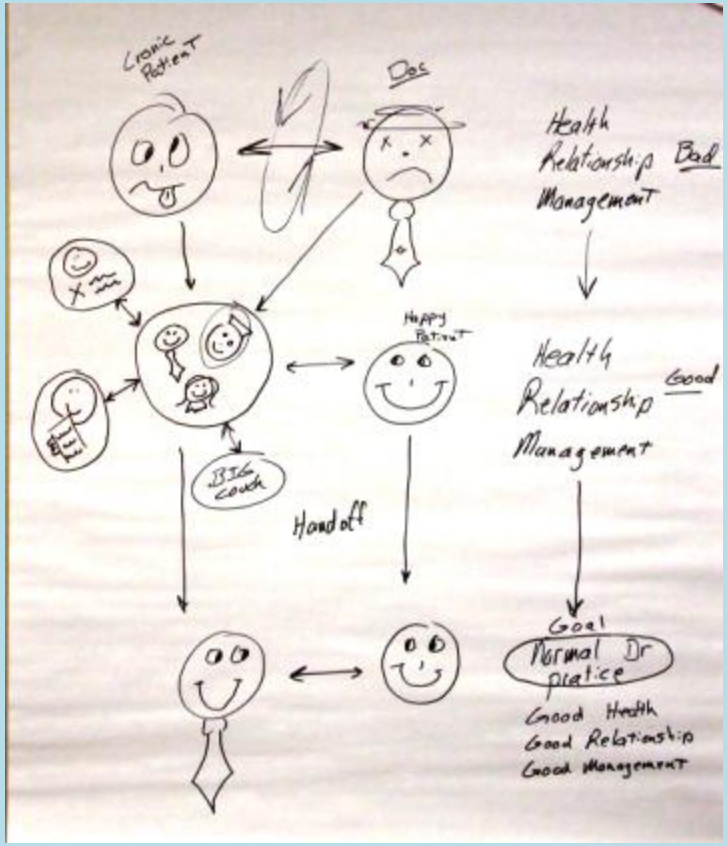
Boeing IOCP Project

- Commercial aged population
- Request by Boeing to try a new care model to improve quality and decrease total cost of care
- TEC Model: Carve out primary care physician (PCP)/partnered with care management RN + behavioral health + clinical pharmacist
- Annual program cost~ $300,000

Year One Results All Sites – Compared to Baseline

Measure	Results
% change in annual per capita spending by patients and Boeing, compared to a matched control group	−20%
% change in SF12 physical functioning	+14.8%
% change in SF12 mental functioning	+16.1%
% change in patient-rated “received care as soon as needed”	+17.6%
% change in average patient-reported work days missed in last 6 months	−56.5%

Patient Perspective



Boeing Audio

Key Learnings

- High-performing RN Care Managers anchor patient and team
- Behavioral health key in complex patient care
- Multidisciplinary team rounds = MD + RN + RPh provide opportunities for continued care improvement
- Medication compliance awareness increased by using pharmacy claims data
- Hospital/ER/Urgent Care electronic tracking tool essential for coordinating patient's care

Care Management Programs 2011–2012 at TEC

- Partners in Palliative Care
- Advanced Care Coordination
- Transition Management
- New PCP Model

Two Patients

Patient A

Patient B

Key Elements for All Programs

- RN Care Manager anchor
- Right care at the right place for patients
- Flagging in electronic systems to identify patients
- Proactive calls at key intervention points
- ACORN Screening Tool and Behavioral Health interventions, including clinical team support

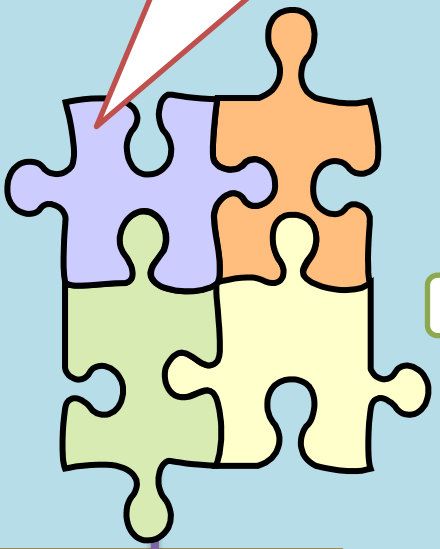
Partners in Palliative Care

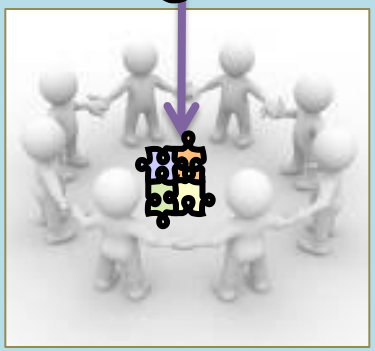
- Jointly led by Providence Hospice and The Everett Clinic
- Patients do not need to be homebound
- Patient are eligible if their provider would not be surprised if they passed away in the next 2 years
- Program annualized cost ~$700,000

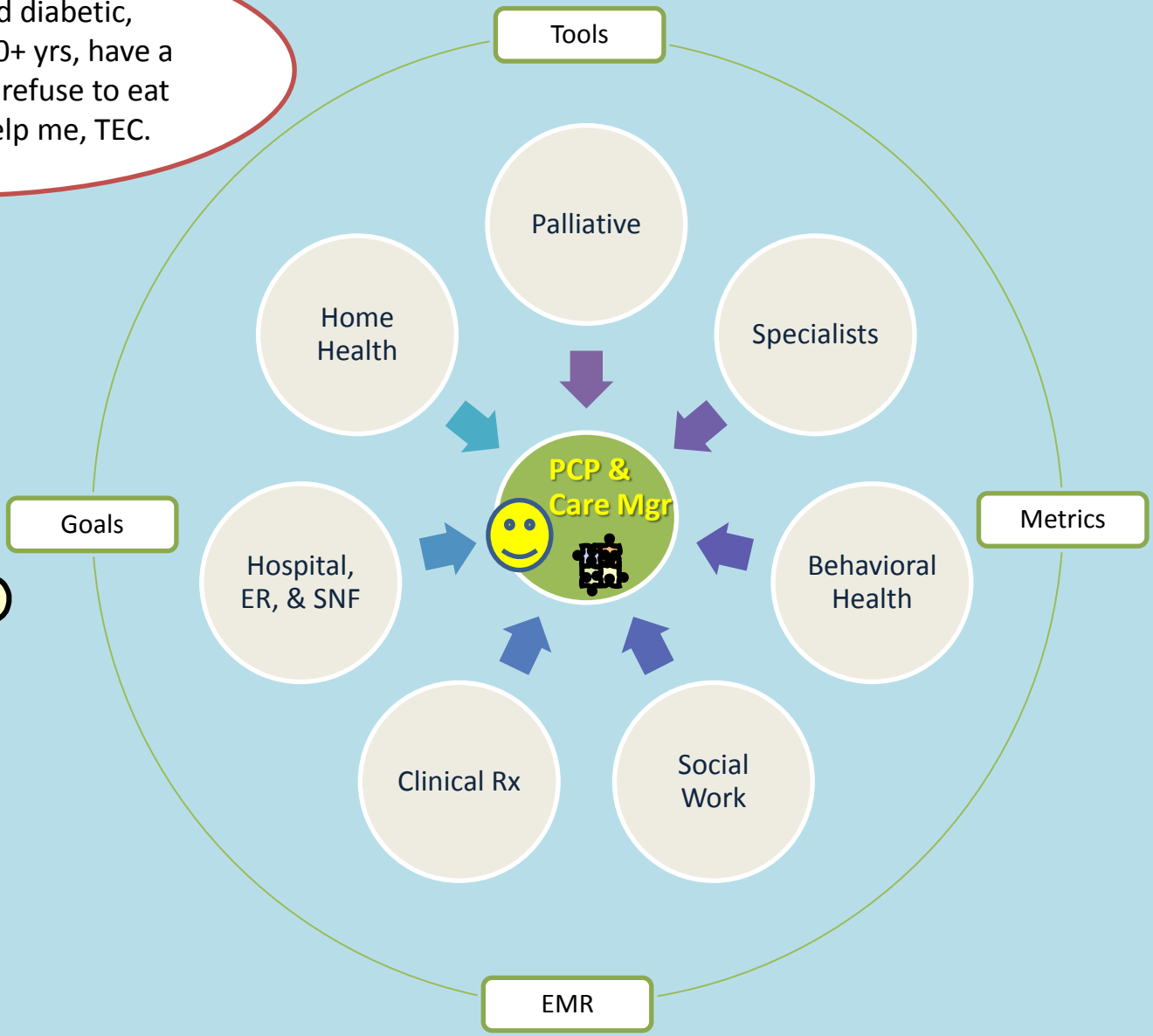
Advanced Care Coordination

- Took on key elements of our experiences—expanded to all TEC primary care sites
- Integrating behavioral health, social work, and clinical pharmacy
- Rapid access to care team is critical
- Challenging to size and scale it across populations and locations

I am a 52-year-old diabetic, obese, smoker for 30+ yrs, have a high-stress job, and refuse to eat anything green. Help me, TEC.







Transition Management

- Based on the work of Eric Coleman, MD
- Team at the hospital and skilled nursing facility (SNF)
- Focus on the four pillars
  - Why are they in the hospital/SNF?
  - Where is their next touchpoint for care?
  - What red flags should the patient be aware of?
  - Medication management

Key Team Traits and Skill Enhancement

- Engaged providers are key
- Right skilled teammates to do the work
- Clinical teams able to work on a level playing field
- Enjoy complex patients
- Embrace and deliver a holistic approach to care, including social and psychosocial issues
- Population management
- Challenges in scaling up

Hospice Care

- Will this patient likely die in the next 6 months?
- Hospice patients live longer than similar aggressively managed patients with less pain and improved patient and family satisfaction and, on average, $8,000 less cost of care
- Cost of care: “Letting Go” Atul Gawande

New PCP Model – Under Development

- Team cares for smaller number of very complex/fragile patients
- Scheduling template: two patients per hour with time for virtual visits (phone, MyChart)
- Pilot planned for January 2012
- New physician compensation model

Physician Compensation

Current:

- 95% Production, RVU based
- Care Coordination Stipend
  - Panel size x HCC RAF Score x Conversion Factor

Physician Compensation *continued*

Proposed:

- Base Salary
- Incentive Bonus
  - Patient satisfaction – Press Ganey
  - Quality measures
  - Documentation and coding
  - Institutional utilization
    - ER
    - Inpatient
    - SNF

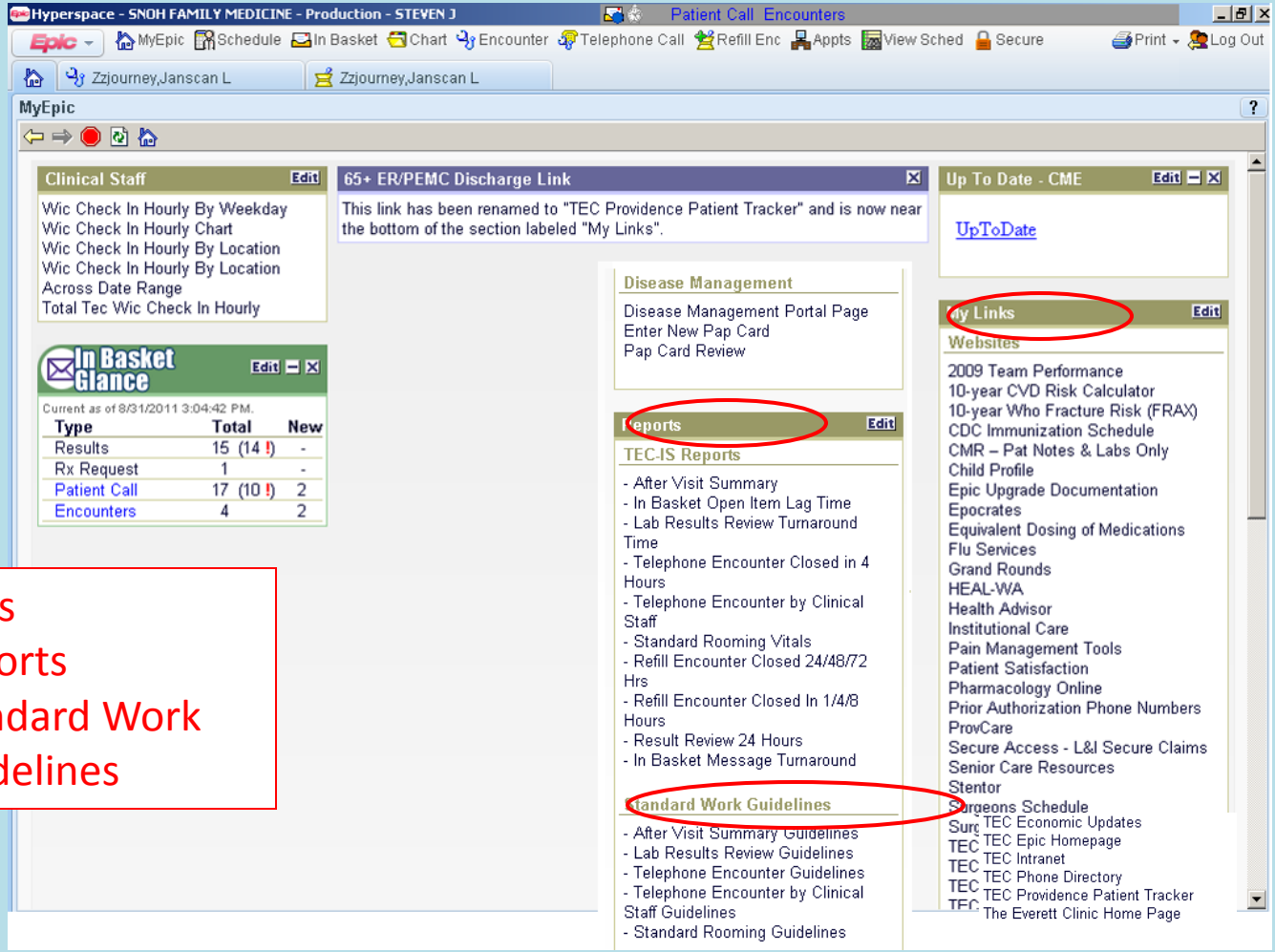
TEC Information Technology Approach

- Right tools to the right audience
  - Clinic wide
  - Satellite
  - Microteam
- Make it easy to do the right thing
- Continual improvement – our journey began over 5 years ago
- Reality of multiple systems, internal and external data

Electronic Medical Record (EMR) Front Page ("Snapshot")

- In-Basket
- On-Line Information Resource
  - UpToDate
- Links *
- Disease Management *
- Reports *
- Standard Work *

EPIC Front Page

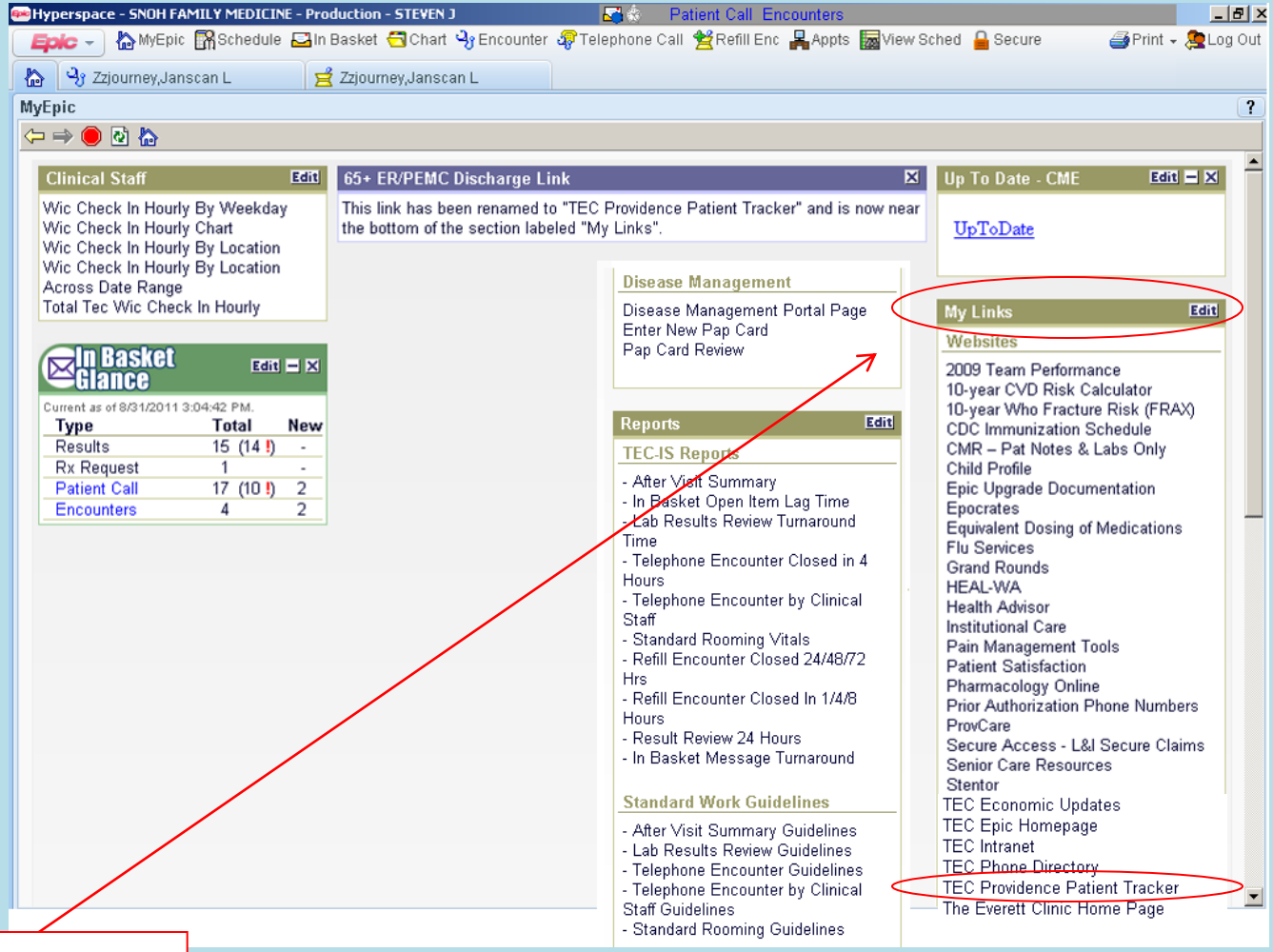


- Links
- Reports
- Standard Work Guidelines

EMR Front Page ("Snapshot")

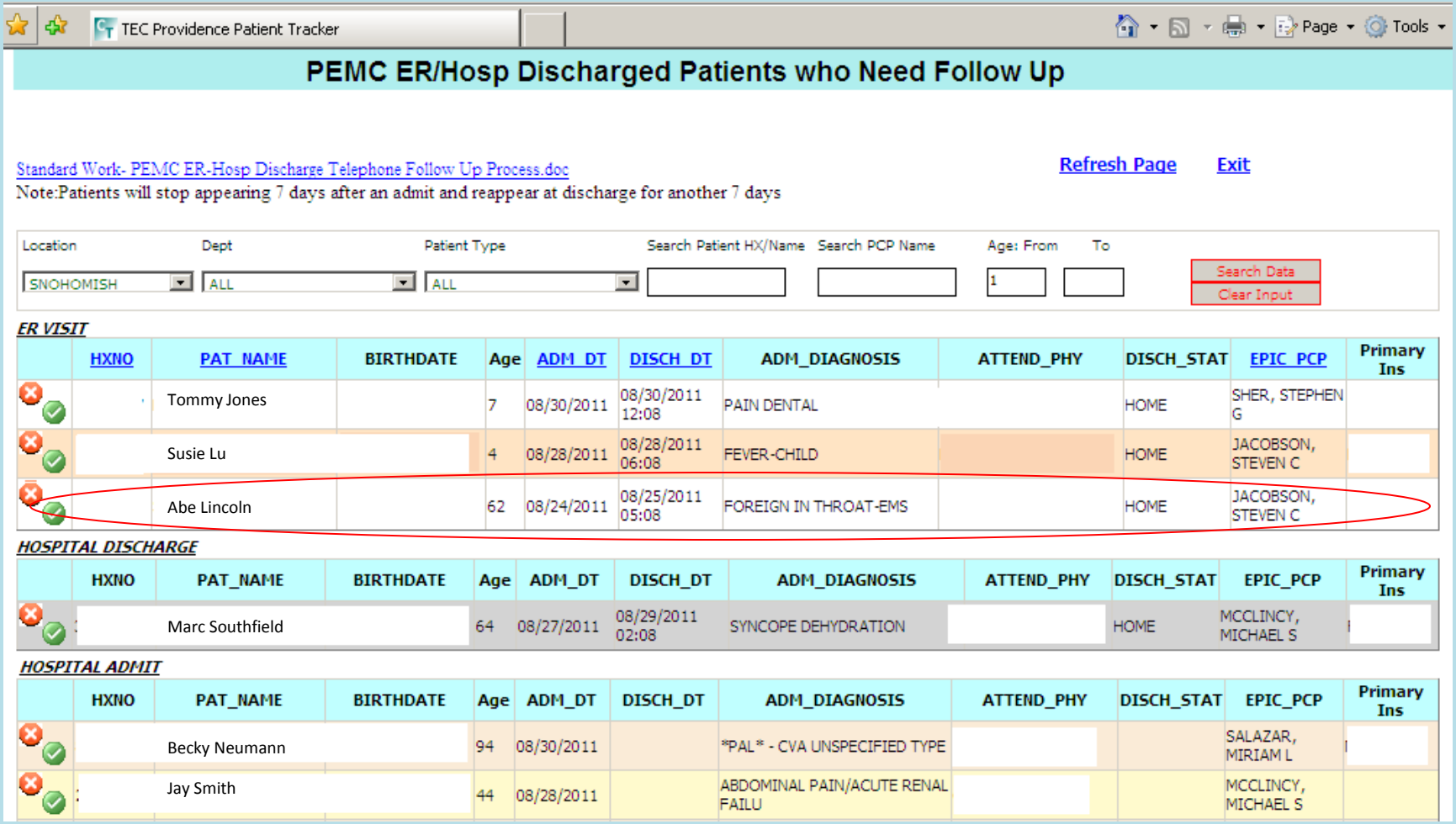
Links

- CDC
- Epocrates
- Pharmacology On-Line
- Institutional Care
- ProvCare
- **TEC Providence Patient Tracker**



EPIC Links

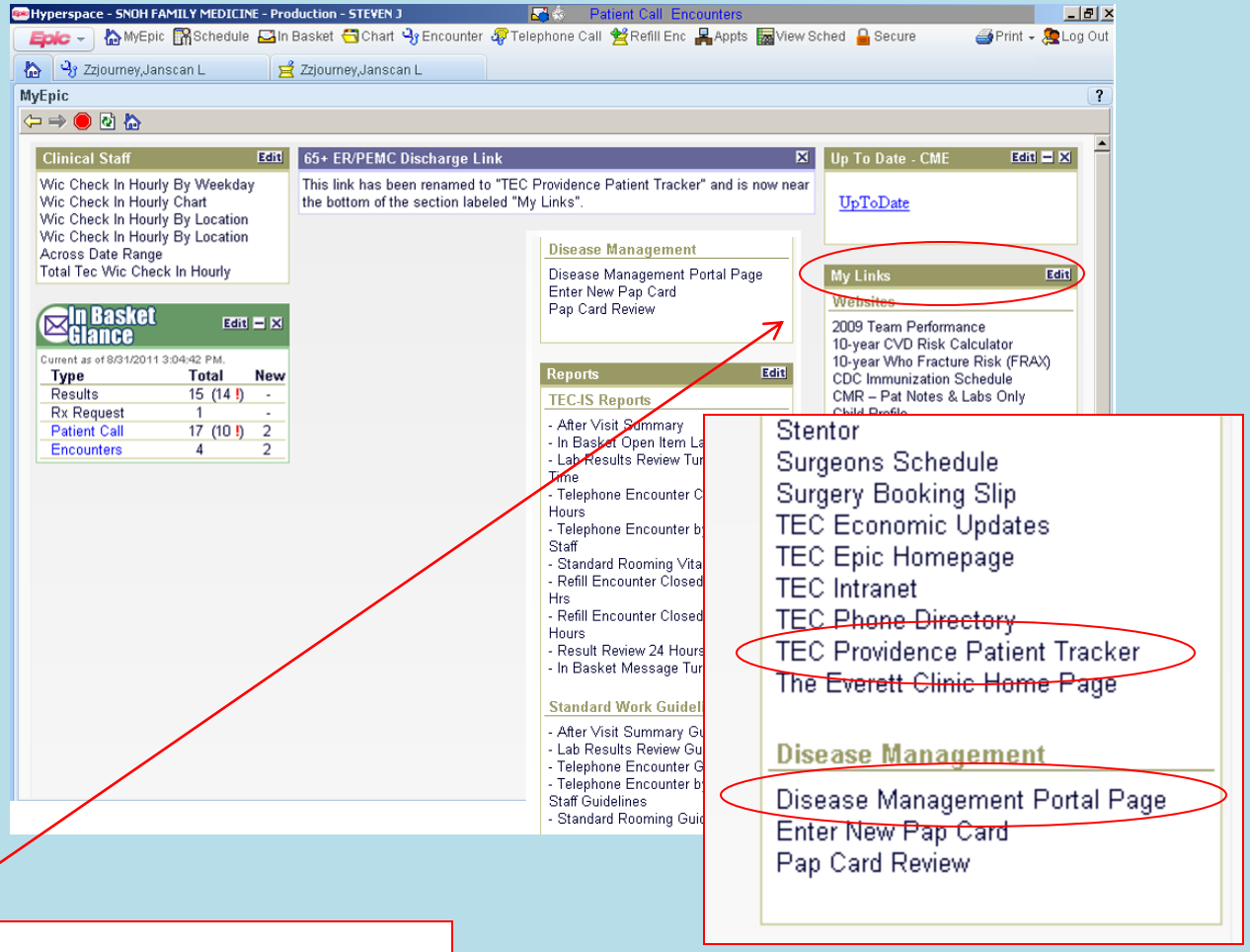
TEC Prov Patient Tracker



EMR Front Page ("Snapshot")

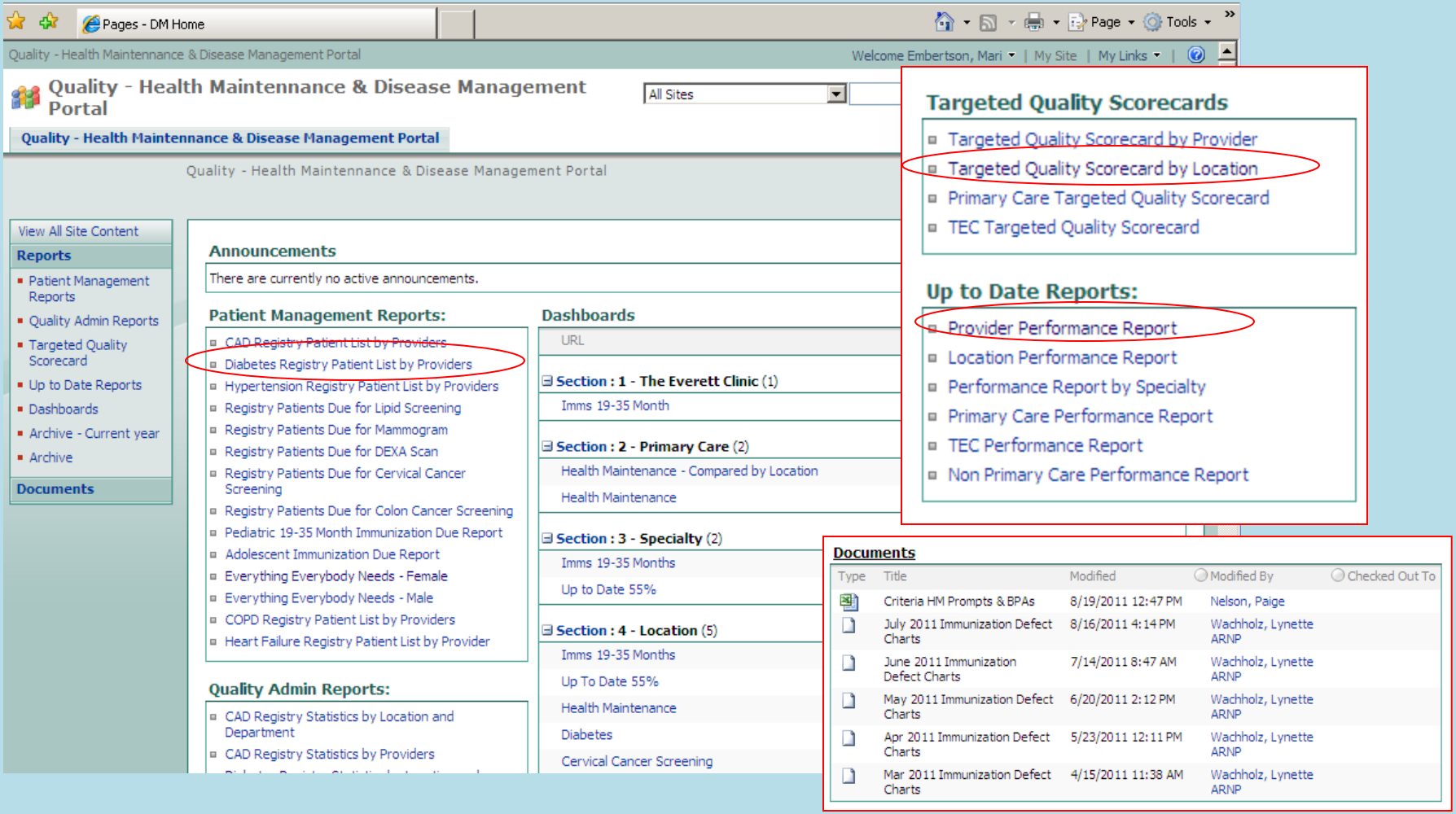
Disease Management

- Patient Management Reports
- Dashboards
- Quality Admin Reports
- Targeted Quality Scorecards
- UpToDate reports



Disease Management

Disease Management



Targeted Quality Scorecard

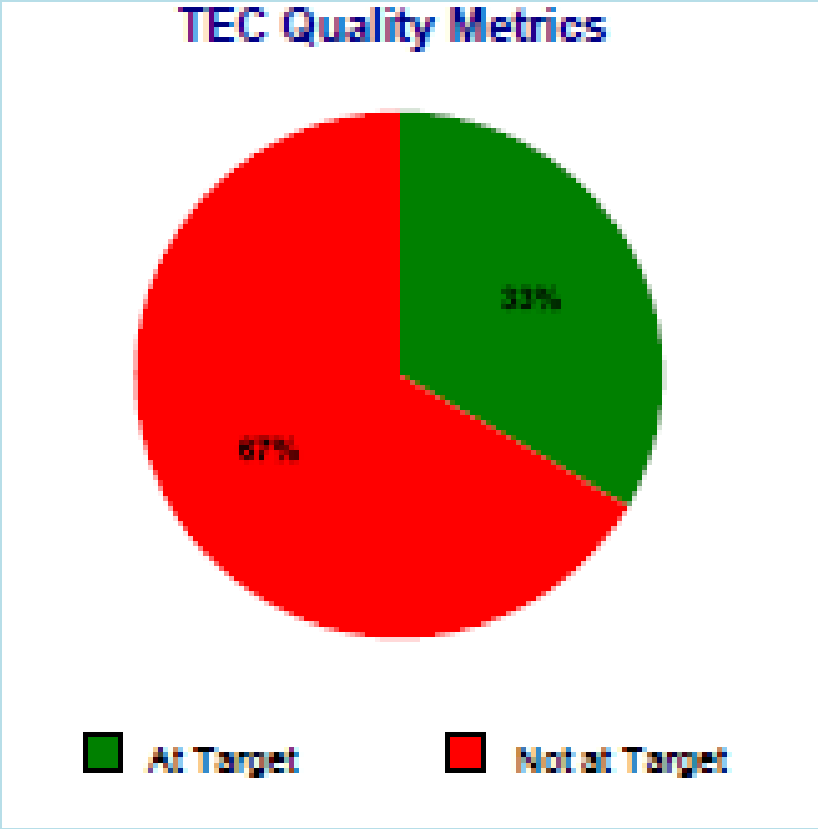
***Diabetes** ***COPD** ***Heart Failure** ***Health Maintenance**

The Everett Clinic
For the whole you

8/31/2011

EVERETT CLINIC SNOHOMISH Targeted Quality Scorecard

	Metrics	Measure Description	Panel Size	Target	Provider Performance
Diabetes	HbA1c Control	Percent patients 18-75 years with HbA1c < 7.0%	503	40%	40.5%
	HbA1c Uncontrolled	Percent patients 18-75 years with HbA1c > 9.0%	503	<=13%	10.7%
	BP Control	Percent patients 18-75 years with BP < 130/80	503	25%	47.5%
	LDL-C Control	Percent patients 18-75 years with LDL-C <100 mg/dl	503	61%	50.1%
COPD	Spirometry	Percent of patients with active Chronic Obstructive Pulmonary Disease who got appropriate spirometry testing to confirm the diagnosis.	205	83%	18.0%
	Hospital Follow-up Visit	Patient with a discharge diagnosis of COPD seen within 7 days of hospital discharge.	8	60%	50.0%
Heart Failure	LVEF Assessment	Percentage of patients aged 18 years and older with a diagnosis of heart failure for whom the quantitative or qualitative results of a recent or prior (any time in the past) LVEF assessment is documented within a 12 month period	67	78%	74.6%
	Use of ACE or ARB, if LVSD	Percentage of patients aged 18 years and older with a diagnosis of heart failure with a current or prior LVEF < 40% who were prescribed ACE inhibitor or ARB therapy either within a 12 month period when seen in the outpatient setting or at hospital discharge	14	82%	78.6%
	Hospital Follow-up Visit	Patient with a discharge diagnosis of HF seen within 7 days of discharge	14	60%	64.3%
Health Maintenance	Screening for Depression if patient had DM,COPD or HF	Percent of patients with diagnosis of diabetes, COPD, or HF who have been screened for depression using ACORN during past 12 months (or who have current diagnosis of depression).	786	50%	21.1%
	Colorectal Cancer Screening	Percent of patients 50-75 years who had appropriate screening for colon cancer.	3269	70%	69.7%
	Tobacco Cessation Intervention	Percentage of patients 18 years and older identified as tobacco users within the past 24 months and have been seen for at least 2 office visits, who received cessation intervention.	1581	75%	44.4%



Diabetes Registry

***HbA1c *BP *LDL *Eye Exam *Foot Exam**

The Everett Clinic
For the whole you

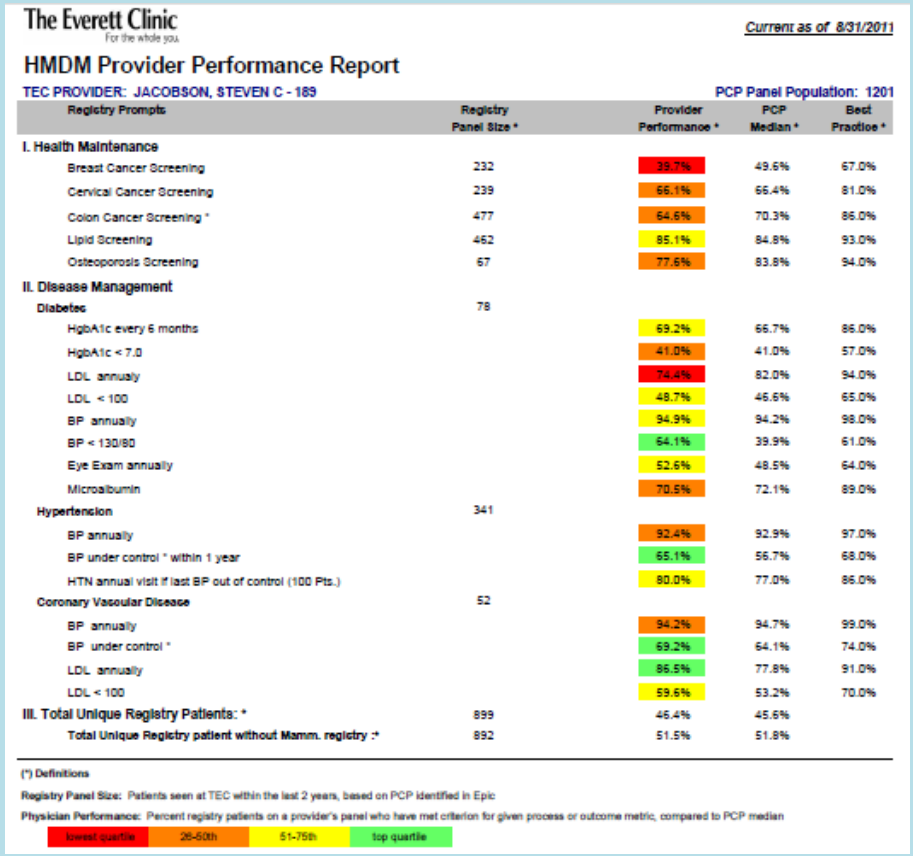
Current as of 8/31/2011

Diabetes Registry Statistics by Location and Department - Detail

EVERETT CLINIC SNOHOMISH

Department / Provider	Total Activ Patients	# and % Patients with HbA1c in last 6 months		# and %patients with HbA1c in control <7.0		% patients with HbA1c >9.0		Average HbA1c last 6 months	# and % Patients with BP < 130/80		# and % Patients with LDL in last year		# and % Patients with LDL <100 in last year		# and % Patients with Microalbumin in last year		# and % patients with Eye Exam in last year		# and % Patients with Foot Exam in last year	
Family Practice																				
IHLE, LOREN J - 200	140	105	75.0%	67	47.9%	11	7.9%	7.2	72	51.4%	127	90.7%	80	57.1%	108	77.1%	87	62.1%	118	84.3%
JACOBSON, STEVEN C - 189	78	54	69.2%	32	41.0%	2	2.6%	7.2	50	64.1%	58	74.4%	38	48.7%	55	70.5%	41	52.6%	61	78.2%
MCCLINCY, MICHAEL S - 943	130	85	65.4%	41	31.5%	20	15.4%	7.6	49	37.7%	95	73.1%	63	48.5%	92	70.8%	70	53.8%	91	70.0%
MCCLINCY, WHITNEY PAIGE - 898	44	29	65.9%	17	38.6%	4	9.1%	7.2	20	45.5%	36	81.8%	23	52.3%	23	52.3%	15	34.1%	18	40.9%
Family Practice:	**392**	**273**	**69.6%**	**157**	**40.1%**	**37**	**9.4%**	**7.3**	**191**	**48.7%**	**316**	**80.6%**	**204**	**52.0%**	**278**	**70.9%**	**213**	**54.3%**	**288**	**73.5%**
Internal Medicine																				
SALAZAR, MIRIAM L - 237	109	86	78.9%	49	45.0%	13	11.9%	7.4	55	50.5%	88	80.7%	50	45.9%	80	73.4%	67	61.5%	59	54.1%
WAY, JENNY Y - 877	67	51	76.1%	34	50.7%	5	7.5%	7.2	26	38.8%	61	91.0%	38	56.7%	57	85.1%	28	41.8%	43	64.2%
Internal Medicine:	**176**	**137**	**77.8%**	**83**	**47.2%**	**18**	**10.2%**	**7.3**	**81**	**46.0%**	**149**	**84.7%**	**88**	**50.0%**	**137**	**77.8%**	**95**	**54.0%**	**102**	**58.0%**
EVERETT CLINIC SNOHOMISH	**568**	**410**	**72.2%**	**240**	**42.3%**	**55**	**9.7%**	**7.3**	**272**	**47.9%**	**465**	**81.9%**	**292**	**51.4%**	**415**	**73.1%**	**308**	**54.2%**	**390**	**68.7%**

UpToDate: Provider Performance Report



The Everett Clinic
For the whole you

Current as of 8/31/2011

HMDM Provider Performance Report

TEC PROVIDER: JACOBSON, STEVEN C - 189 — PCP Panel Population: 1201

Registry Prompts	Registry Panel Size *	Provider Performance *	PCP Median *	Best Practice *
I. Health Maintenance				
Breast Cancer Screening	232	39.7%	49.6%	67.0%
Cervical Cancer Screening	239	66.1%	66.4%	81.0%
Colon Cancer Screening *	477	64.6%	70.3%	86.0%
Lipid Screening	462	85.1%	84.8%	93.0%
Osteoporosis Screening	67	77.6%	83.8%	94.0%
II. Disease Management				
Diabetes	78			
HgbA1c every 6 months		69.2%	66.7%	86.0%
HgbA1c < 7.0		41.0%	41.0%	57.0%
LDL annually		74.4%	82.0%	94.0%
LDL < 100		48.7%	46.6%	65.0%
BP annually		94.9%	94.2%	98.0%
BP < 130/80		64.1%	39.9%	61.0%
Eye Exam annually		52.6%	48.5%	64.0%
Microalbumin		70.5%	72.1%	89.0%
Hypertension	341			
BP annually		92.4%	92.9%	97.0%
BP under control * within 1 year		65.1%	56.7%	68.0%
HTN annual visit if last BP out of control (100 Pts.)		80.0%	77.0%	86.0%
Coronary Vascular Disease	52			
BP annually		94.2%	94.7%	99.0%
BP under control *		69.2%	64.1%	74.0%
LDL annually		86.5%	77.8%	91.0%
LDL < 100		59.6%	53.2%	70.0%
III. Total Unique Registry Patients: *	899	46.4%	45.6%	
Total Unique Registry patient without Mamm. registry :*	892	51.5%	51.8%	

(*) Definitions

Registry Panel Size: Patients seen at TEC within the last 2 years, based on PCP identified in Epic

Physician Performance: Percent registry patients on a provider's panel who have met criterion for given process or outcome metric, compared to PCP median

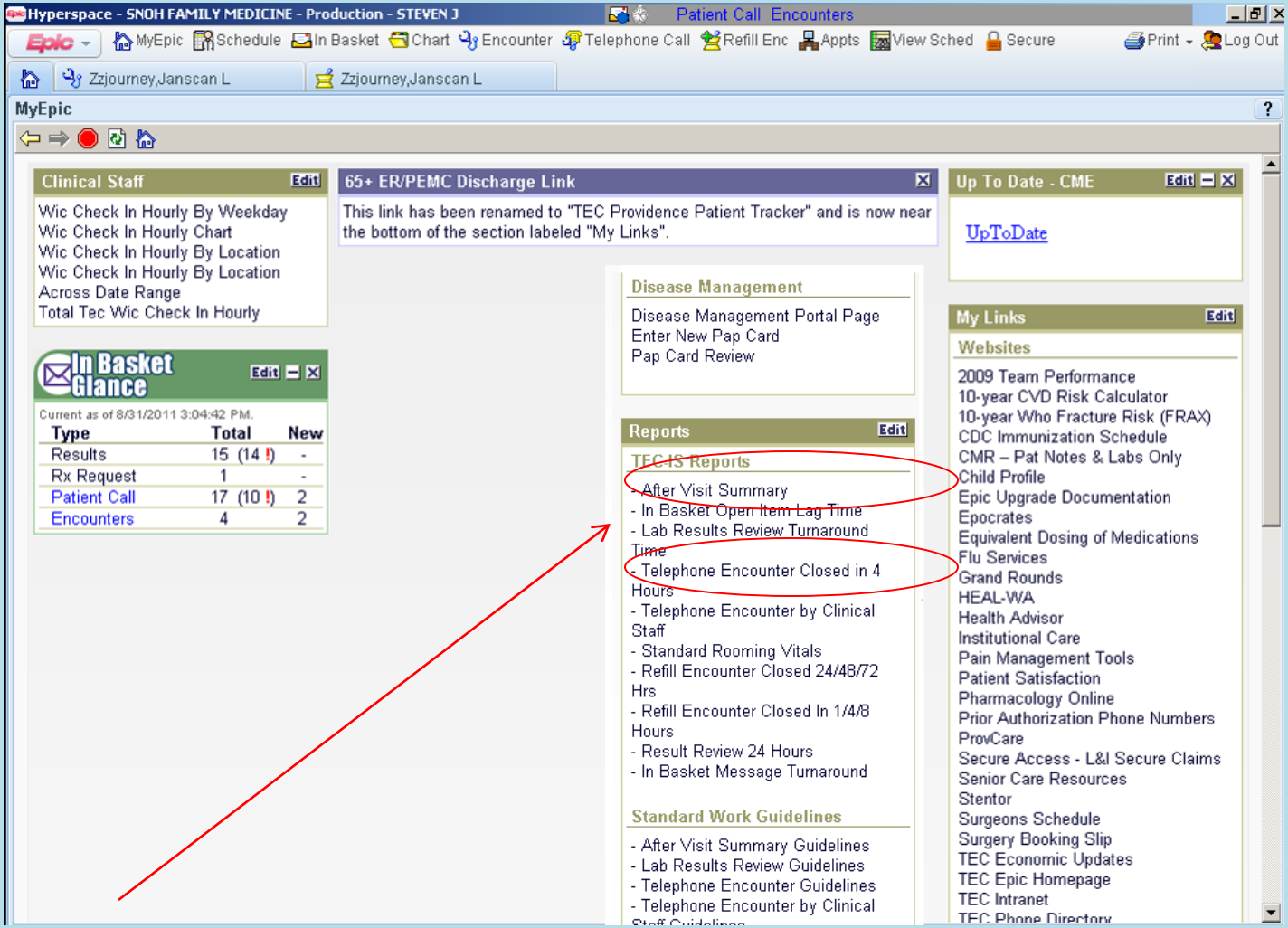
lowest quartile | 26-50th | 51-75th | top quartile

- Health Maintenance Screenings
- Disease Management Metrics
  - Diabetes
  - Hypertension
  - Coronary Vascular Disease
- Performance
  - Individual Provider
  - PCP Median
  - Best Practice

EMR Front Page ("Snapshot")

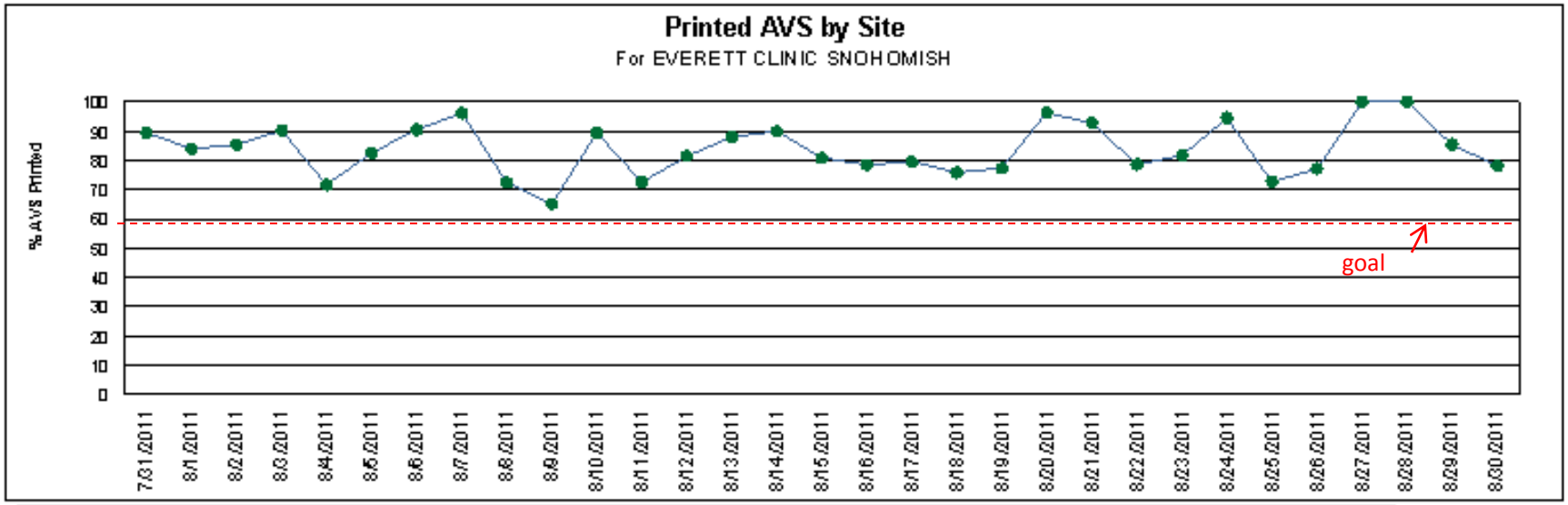
Reports (examples)

- After Visit Summary
- Telephone Encounter Closed in 4 hours
- Standard Rooming Vitals
- In Basket Message Turnaround



After Visit Summary Report

EVERETT CLINIC SNOHOMISH



7/31	8/1	8/2	8/3	8/4	8/5	8/6	8/7	8/8	8/9	8/10	8/11	8/12	8/13	8/14	8/15	8/16	8/17	8/18	8/19	8/20	8/21	8/22	8/23	8/24	8/25	8/26	8/27	8/28	8/29	8/30
89	84	85	90	72	83	90	96	72	65	89	73	81	88	90	81	78	80	76	77	96	93	79	82	95	73	77	100	100	85	78

Telephone Encounters Report

The Everett Clinic
For the whole you

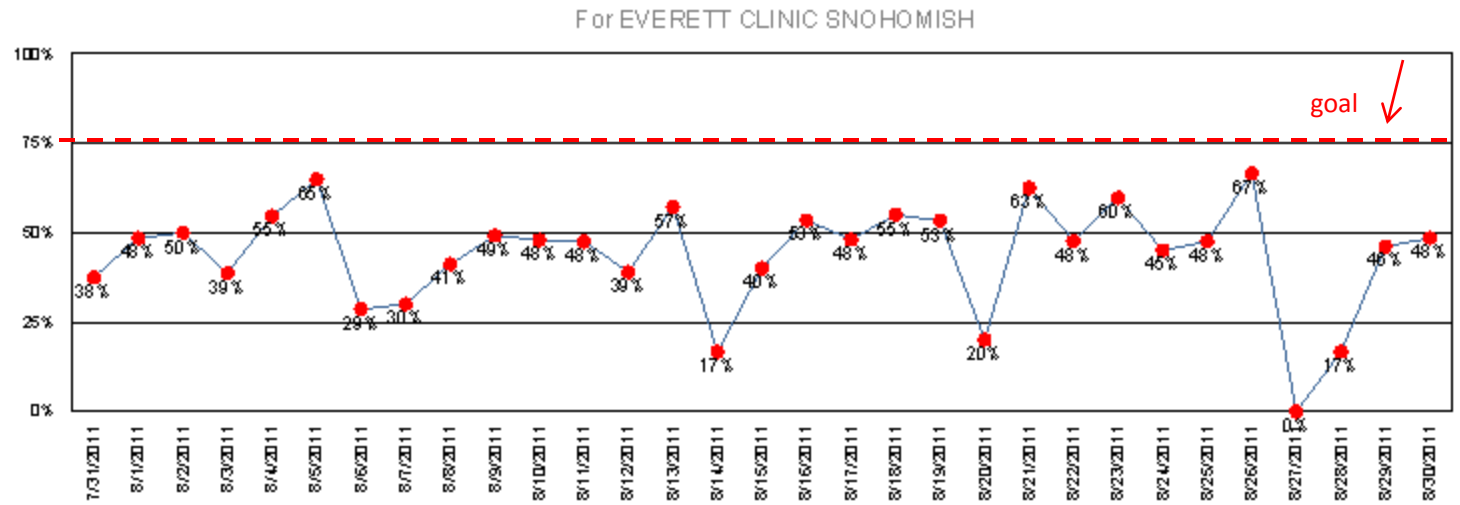
TEC Telephone Encounters Closed In 4 Hours

Report Description: Percent of Telephone Encounters closed within 4 hours of being generated.
Goal: 75% of all Telephone Encounters opened are resolved and closed within 4 hours of being generated.

8/31/2011

From 8/1/11 To 8/31/11

EVERETT CLINIC SNOHOMISH



EMR Front Page ("Snapshot")

Standard Work

- After Visit Summary
- Lab Results Review
- Telephone Encounter
- Standard Rooming

Primary Care Visit Tools

- Smart Sets
- Documentation Tools
- Coding Tools
- Evidenced-Based Imaging
- Pre-Visit Planning
- Problem List Prioritization

Information Flow Management

- Send This …
- Don’t Send This …
  - Normal mammograms
  - Normal EGDs
  - Normal colonoscopies
  - Follow-up visit notes with no significant changes

Conclusion

- Identifying patients can be done through a variety of mechanisms
- Care management programs are key, require teams and continuous improvement
- All programs can be developed incrementally, but will take time, energy, and resources
- Electronic systems and reports are helpful in improving the identification, documentation, and tracking of patients

Module 3B. Connecting Providers and Managing High-Risk Patients

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