Care Coordination Transformation: Road to Population Health

Session #112
February 21, 2017
Speaker Introductions

Christy Kaplan
Vice President of Care Coordination and Integration
John Muir Health

Susan Tolin
Consultant, Care Coordination Transformation
The Chartis Group
Conflict of Interest

Christy Kaplan and Susan Tolin:

Have no real or apparent conflicts of interest to report.
Agenda

1. Background
2. Approach
3. Results To-Date
## Learning Objectives

1. Describe one approach to addressing the move to full and partial payor risk agreements through integrated care coordination programs focused on the managing complex disease and psychosocial needs of the population.

2. Apply lessons learned from experiences to design a care transitions services “centralized hub” to perform tasks related to care transition and authorization processes.

3. Detect opportunities for creating a cohesive care management approach, reducing duplication of activities and encouraging top-of-licensure clinician work.

4. Describe best practices for redesigning workflows to identify patients with the most urgent care needs.

5. Explain the importance of gathering metrics throughout the initiative to ensure that goals are achieved and support organizational strategic initiatives.
An Introduction of How Benefits Were Realized for the Value of Health IT

(S) **Satisfaction**: Improved patient experience, staff experience, transparency in workloads. Staff working to top of licensure; 40% less time for an ambulatory RN case manager to complete initial assessment

(T) **Treatment / Clinical**: Reduced readmissions, unnecessary admissions, and ED visits; standardized care models for chronic diseases

(E) **Electronic Secure Data**: Reduction of dependence on third-party clinical applications

(P) **Patient Engagement**: More robust patient outreach and activation of high-risk patients

(S) **Savings**: Reduction and redeployment of FTEs, reduction in LOS, reduced reliance on third-party applications
<table>
<thead>
<tr>
<th>Background</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approach</td>
</tr>
<tr>
<td>Results To-Date</td>
</tr>
</tbody>
</table>
Long-Term Commitment to the Community

- Concord Community Hospital Opens
- John Muir Memorial Hospital Opens
- Formation of John Muir Physician Network
- Two hospitals merge forming what is now John Muir Health
- Brentwood Outpatient Center Opens
- Partnerships with Stanford Children’s Health, Tenet Healthcare/San Ramon Regional Medical Center and UCSF Health
- John Muir Health remains strong, independent, not-for-profit, community-based health system
Community-Based, Not-for Profit

• Three Hospitals
• Behavioral Health Pavilion and Hospital
• John Muir Physician Network
  – Over 1,000 primary care and specialty physicians
  – John Muir Medical Group, Muir Medical Group, IPA
  – Five major outpatient centers, including our newest in Pleasanton
  – Physician offices throughout Contra Costa, southern Solano and eastern Alameda counties
• Full-range of medical services
  – Primary care, specialty care, inpatient, outpatient and imaging services
• Leader in virtually all specialties
  – Neurosciences, orthopedic, cancer, cardiac, trauma, emergency, pediatrics and high-risk obstetrics care
• Nationally recognized for clinical quality
• Very strong brand awareness in the community
Recent JMH Awards and Recognitions

1. Best Hospitals
2. High Performing Hospitals
3. Best Regional Hospitals
4. America's 50 Best Hospitals
5. Distinguished Hospital Clinical Excellence™
6. Outstanding Patient Experience Award™
7. CAPG: The Voice of Accountable Physician Groups
8. Joint Commission for National Quality Service
9. Magnet Recognized: American Nurses Credentialing Center
Significant and Financially Strong

**SIZE / ACTIVITY**
- 1,037 Beds
- 30,000+ Hospital Admissions
- 500,000 PCP/Urgent Care Visits
- 100,000+ Emergency Dept. Visits
- 3,000 Newborns

**HUMAN RESOURCES**
- 6,000 Employees
- 1,600 Volunteers
- 1,200 Physicians
- 1,600 Volunteers
- 1,200 Physicians

**FINANCIAL FOUNDATION**
- Credit rating of A+ or equivalent by S&P’s and Moody’s
- $117M Community Benefit
- $1.5B Revenue
- Strong Balance Sheet

$1.5B + Revenue
Care Coordination Transformation
Our Mission and Vision

**Our Mission:**
Dedicated to improving the health of the patients we serve with quality and compassion through evidence-based coordinated care across the care continuum
Background

• Care Coordination and Integration Service Line
  – All the departments within the continuum
  – It is important to acknowledge and understand the importance of the continuum
    • Not just inpatient and outpatient
    • Ancillaries (home health, wellness services, disease management services)
Improving Care – Holistic Approach

- **End of Life**
  - Hospice, Palliative
  - Care Team/CM, End of Life Planning
  - Preventive Care

- **Complex, MCC (High Risk)**
  - Visits, Monitoring

- **Chronic Conditions, Psychosocial (Rising Risk)**
  - Visits, Monitoring

- **“Simple” Chronic Condition (Low Risk)**

- **Prevention, Wellness, Patient Engagement (Healthy)**

- **JMH Patients and Providers**

**Care Team**
- PCPs
- Specialists
- Hospitalists
- IP Case Management
- OP Care Coordination Programs
End of Life Care

Complex Care Coordination Services

Prevention Wellness Services
Population Management

Data Warehouse identifies patients and determines appropriate healthcare level “continuous loop”
Approach

• Key Stakeholders:
  – Hospitals
  – Finance
  – Physician Network
  – Information Technology

• The balanced approach marries the need to meet the current state between volume and value

• Care Coordination efforts—when done right—result in the assurance that patients are at the correct level of care and receiving the appropriate resources to maintain health status
The Approach

- Expertise
- Reduce duplication/waste
- Key responsibilities
- Escalation for problem solving
- Culture shifts
- “Sand-box to Beach”

- Supports work and people
- Efficient
- Intuitive
- Engages in all care team as well as patient
- Continuity and transparency

- Top of license
- Patient centric/experience
- Total Cost/Outcome Care
- Interdisciplinary
- Time Sensitive
- Evidenced-Based
Care Coordination Transformation
Ambulatory and Inpatient Program Integration

- Case Management
- Social Services
- Palliative Care
- Ambulatory Social Work
- Home Health Agency
- Preferred Partners Network
## Integration

<table>
<thead>
<tr>
<th>Before</th>
<th>After</th>
</tr>
</thead>
</table>
| Place Centric not Patient Centric | Longitudinal plan of care  
Patient “life plan” |
| Duplication, waste, variability | Standardized job descriptions  
Top of license  
Defined functions measured (dashboards) |
| Very little communication, ineffective hand-offs and finger pointing | Integrated Care Plan, shared accountability |
| Silos and isolated work teams | Patient centric, multidisciplinary teams, care conferences, timely escalation |
| Little actionable, real-time or outcome data | Dashboards for frontline staff and management  
Registries and patient populations defined for all levels of the health pyramid |
| Single EMR, varying views, 2-3 additional systems to support work | Single EMR for all departments in the continuum, seamless hand-offs, measurable outcomes |
| Reactive care management programs | Proactive patient identification, timely care planning, enrollment/placement in the appropriate level of care or program |
## Care Coordination Metrics

<table>
<thead>
<tr>
<th>Productivity</th>
<th>Outcomes</th>
<th>Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Standardized, evidenced-based and measureable practices</td>
<td>• Proactive monitoring for length of stay</td>
<td>• Identify gaps in care across the continuum</td>
</tr>
<tr>
<td>• Patients’ care transition needs assessed within 24 hours</td>
<td>• ED utilization and throughput</td>
<td>• Patients enrolled in disease management programs (Diabetes, Heart Failure, others)</td>
</tr>
<tr>
<td>• Patient classification review completed in a timely manner utilizing InterQual</td>
<td>• Patient satisfaction with program services</td>
<td>• Utilizing technology for accurately tracking and reporting measures</td>
</tr>
</tbody>
</table>
Inpatient Case Manager

Utilization Review

Pop Health Panel Management

HUB Referral Process

(Illustrative Only)
Integrated Case Management Documentation
- Population Health management model
- Standardized, evidence-based, patient centric
- Reduce duplication, improved handoffs
- Improved data to support outcomes productivity

Patient Centric Longitudinal Care Plan
- All care team members may view and contribute
- Linked to social determinants of care
- Provides pertinent real-time information at each touch point

Care Transitions Hub Development
- Centralized staff to support the transition of patients to the most appropriate level of care

Innovation and Technology
Phase 1 Components

Creating Integrated Documentation:

*Patient Centric vs. Encounter Centric*

Evidence based, standardized documentation shared across programs that can be viewed across encounters and is accessible to all members of the care team.

Key Components:

- Standardized OP Assessment
- Shared documentation fields with IP
- Social History
- Scoring Tools
- Social Determinants of Health
- Improved Handoffs
Phase 1 Components (cont’d)

Longitudinal Plan of Care (LPOC):

*Patient Centric vs. Encounter Centric*

LPOC is a shared single plan of care—including care gaps, coordination notes, and goals—that is accessible to all members of the care team.
Clinical Case Management (CCM):

CCM supports case management monitoring of patient’s care while admitted. This module helps with bed requests, monitors patient’s bed days, and flags when a patient has been readmitted. Tools also track and measure performance of case managers and trending via Radar dashboards.

Key Components:

- Patient classification at the correct level of care, such as inpatient or observation
- Patient lists, flow sheets, notes
- Utilization review
- Payer communication
- Discharge placement
- Migration (retirement) or relevant workflow from Allscripts and Midas to Epic CCM
Centralized Care Transitions “HUB”

- Transitions team will provide services to streamline patient transition to the appropriate level of care setting.
- Communicate all patient transfer information to referring and receiving care entities. Notify PCP, arrange post-discharge appointments, ancillary needs such as DME, Post Acute Care provider.
- Reduce ED visits historically used to assess and place patients (to Home Health, SNF, etc.).
- Reduce delays in placement due to authorizations or access issues.
- Improve patient and family experience with efficient and appropriate care resources and processes.
Post-Acute Preferred Network
A partnership to ensure the best quality and access for our patients

• What are the JMH “Preferred Networks”?
• Why are these networks being created?
• How were they selected?
• How will we work with these preferred facilities?
• Does the patient have other choices?
Post-Acute Preferred Skilled Facility Network
A Partnership to Ensure the Best Quality and Access for our Patients
Background

Approach

Results To-Date
Results To-Date

• Shift in Culture
  – Moving teams to the “future State”
  – Technology drives the movement
    • Provides infrastructure for how things are done “now”
    • Provides the infrastructure to support best practice
    • Serves the patients “first”
    • Reinforces Best Practice

• Management also needs to move to a new norm…support the new workflows and optimum patient outcomes
  – Technology supports monitoring teams
  – Outcomes and data are readily available
Culture Change
# Sample Care Coordination Metrics

<table>
<thead>
<tr>
<th>Metric</th>
<th>Current</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of admitted patients whose care transition needs are assessed within 24 hours</td>
<td>Goal with go live is with 24 hours of admission</td>
</tr>
<tr>
<td>% of admitted patients who have a follow-up appointment established prior to leaving the hospital</td>
<td>Now a responsibility of the Care Transition HUB - no accountability before</td>
</tr>
<tr>
<td>Accurate, transparent and real-time utilization data • LOS, Intequeal criteria, avoidable days, ED utilization</td>
<td>Aligned with other healthsystem departments (Quality, Payer Analytics, Clinical Analytics)</td>
</tr>
<tr>
<td>% of patients with a high readmission risk (LACE) who have had a home visit from one of the Case Management programs</td>
<td>New Pop Health Model ensures that CM assignment is included with discharge and appropriate post discharge services are included. (Post PCP visit, home visit, etc.)</td>
</tr>
<tr>
<td>% of admitted patients with high readmission risk who are enrolled with Ambulatory Case Management</td>
<td>Systematic approach to identifying patients through risk stratification—includes engagement of patients prior to a utilization metric such as admission or ED Visit</td>
</tr>
<tr>
<td>ED utilization by patients enrolled in Case Management programs (avoidable)</td>
<td>Post ED Visit calls by CM staff—engage in CM programs proactively—Education most valuable intervention</td>
</tr>
<tr>
<td>Patient, family and provider satisfaction with services received from Care Coordination programs</td>
<td>Evaluation metrics expanded to providers including Case Manager services and support for panel management</td>
</tr>
<tr>
<td>% of patient with a chronic conditions who are actively participating in JMH chronic condition programs</td>
<td>Proactive identification of patients and referral to programs (Diabetes, CHF etc.,)Previous systems referred patients after utilization of IP services.</td>
</tr>
</tbody>
</table>
## Care Coordination Transformation – Communication to all stakeholders …

<table>
<thead>
<tr>
<th>Committee or Meeting Type</th>
<th>Key Stakeholders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Leadership Committee</td>
<td>Volunteer Services</td>
</tr>
<tr>
<td>vows</td>
<td>JMH/San Ramon Regional Integration Committee</td>
</tr>
<tr>
<td>Hospitalist Directors</td>
<td>ACO Congress</td>
</tr>
<tr>
<td>Operations Council</td>
<td>ACO Governance Board</td>
</tr>
<tr>
<td>Information Technology Committee</td>
<td>Strategic Planning Committee</td>
</tr>
<tr>
<td>Nursing Directors Group</td>
<td>CMIO, CIO</td>
</tr>
<tr>
<td>Campus Management Meetings</td>
<td>Performance Improvement Team</td>
</tr>
<tr>
<td>Inpatient Case Management Meetings</td>
<td>System Board Education Session</td>
</tr>
<tr>
<td>Ambulatory Case Management Meetings</td>
<td>Ancillary Services (Physical Therapy, Lab, Respiratory Medicine)</td>
</tr>
<tr>
<td>Chief Medical Officer Medical Director Meeting</td>
<td>Network Leadership Team</td>
</tr>
<tr>
<td>Value Per Case Committee</td>
<td>JMPN Direct Reports Meeting</td>
</tr>
<tr>
<td>Quality Management</td>
<td>Canopy Health – USCF/JMH Partnership</td>
</tr>
<tr>
<td></td>
<td>Post-Acute Care Network Agencies</td>
</tr>
<tr>
<td></td>
<td>Emergency Room Staff</td>
</tr>
<tr>
<td></td>
<td>Urgent Care Centers</td>
</tr>
</tbody>
</table>
## Lessons Learned (so far…)

- Align the approach early; include C-suite stakeholders and frontline staff early and often
- Expect resistance – credit team achievements to motivate
- Course correct or redefine strategy (fail fast)
- Establish the communication plan that can be customized by audience
- Provide opportunities for staff feedback
- Develop a consistent message that is supported by the vision
- Keep IT and Clinical Teams working in tandem
An Introduction of How Benefits Were Realized for the Value of Health IT

(S) Satisfaction: Improved patient health, staff morale, and provider satisfaction; staff working to top of licensure; 40% less time for an ambulatory RN case manager to complete initial assessment

(T) Treatment / Clinical: Reduced readmissions, unnecessary admissions, and ED visits; standardized care models for chronic diseases

(E) Electronic Secure Data: Reduction of dependence on 3rd party clinical applications

(P) Patient Engagement: More robust patient outreach and activation of high risk patients

(S) Savings: Reduction and redeployment of FTEs, reduction in LOS, reduced reliance on third party applications