Transforming Care Delivery: Redesigning Case Management and Primary Care Roles in Population Health Management

PCPCC

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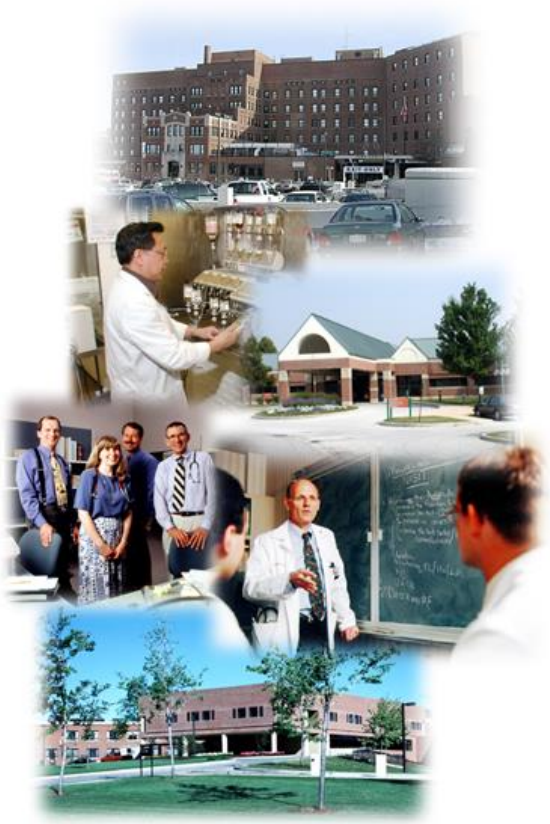
WellSpan® HEALTH

WellSpan Health: Working as one to improve health through exceptional care for all, lifelong wellness and healthy communities



A community-owned, not-for-profit 1.5 billion annual revenue health system in south central PA with 11,000 employees working in:

- 90 sites
- 4 Hospitals
  - *York Hospital – 572 bed Level I Trauma Center*
  - *Gettysburg Hospital – 76 bed community hospital*
  - *Ephrata Community Hospital – 130 beds*
  - *WellSpan Surgery & Rehab Hospital – 73 beds*
- WellSpan Medical Group (WMG)
  - Over 760 employed specialty and primary care providers
  - $200 million annual budget
  - over 1.5 million total visits per year
- 600+ private practice physicians
- 1,000+ volunteers
- Academic center - 8 residencies & 4 fellowship programs
- $175 million annually in charitable and uncompensated care
- We are NOT a hospital-based system (we do not think of ourselves that way, and less than 40% of revenue is from our hospital entities)

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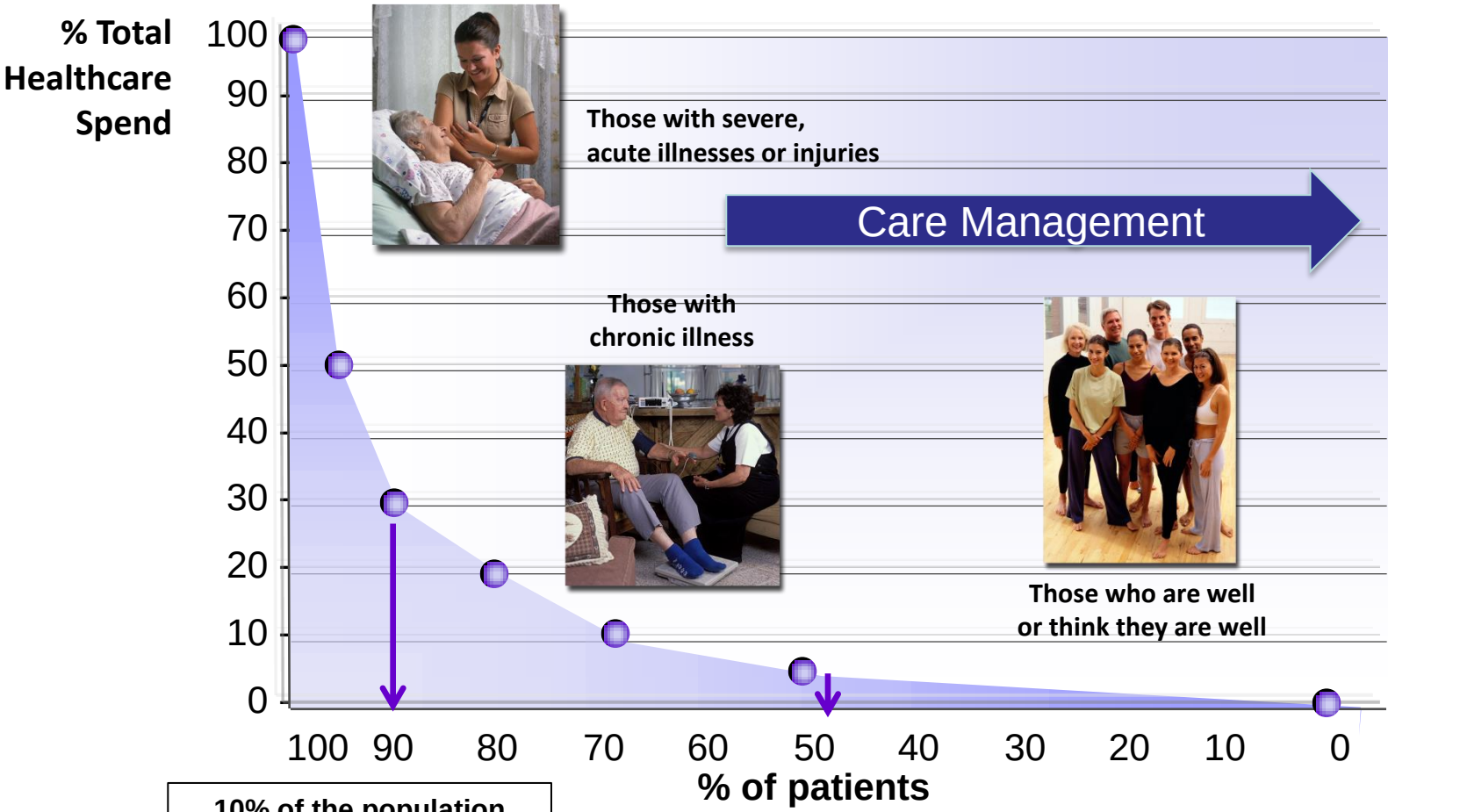
WellSpan's Population Health Strategy Focuses on the Different Needs of People at Different Stages of the Continuum of Care

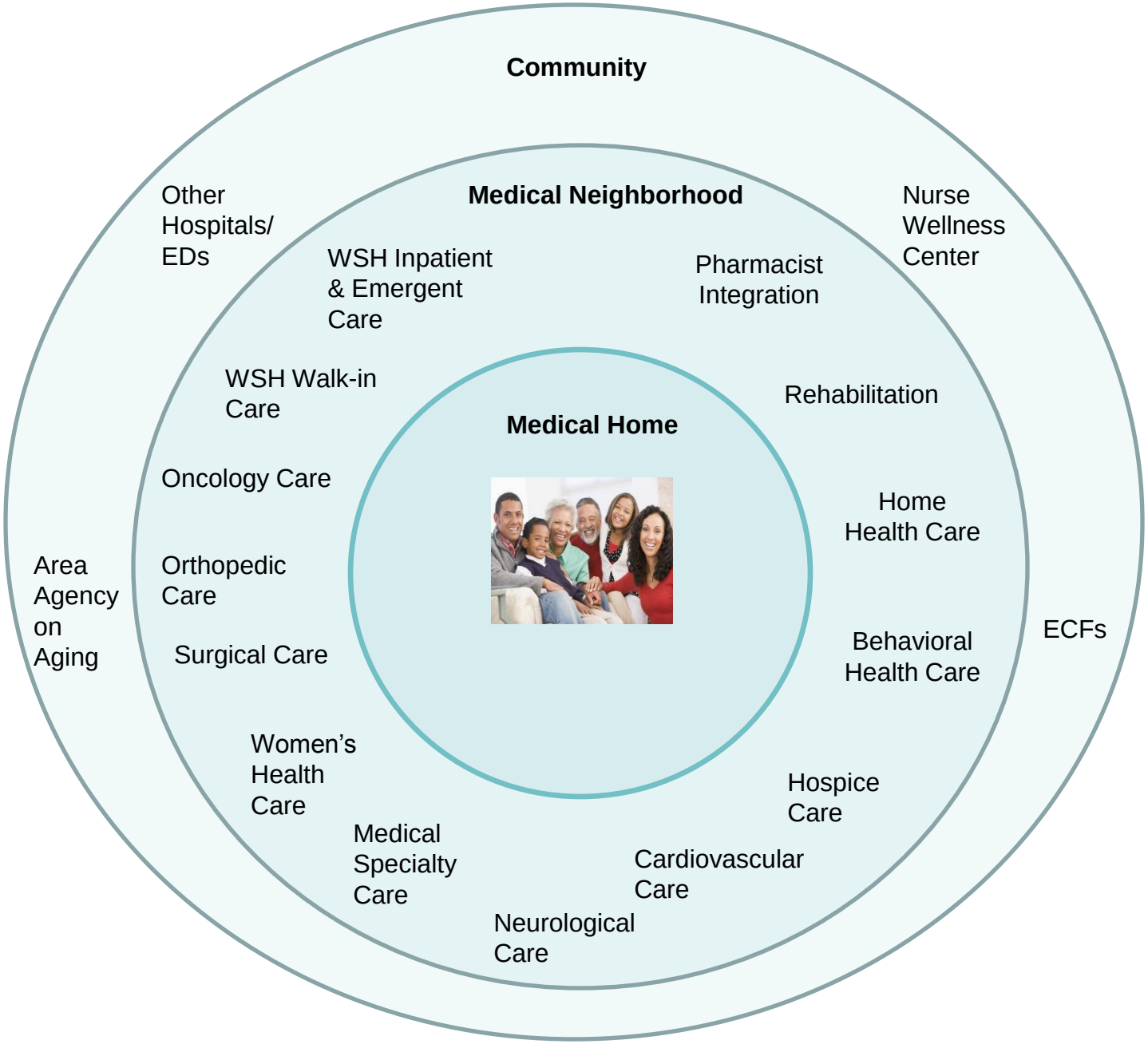


10% of the population consumes 66% of the total spend (member with > $10,000 expenses)

49% of the population consumes only 4% of the total spend (each spends < $1,000)

WellSpan® HEALTH

The Patient-Centered Medical Neighborhood: Striving for the Triple Aim



A New Mental Model for Providers

WellSpan's Medical Neighborhood

From:		To:
My Patient	→	"**Our** Patient"
My clinical preferences	→	**WellSpan's clinical standards** and preferences
Oriented only to **my** practice site	→	Oriented to my practice **within** WellSpan's neighborhood
My plan for the patient	→	**The patient's** Shared Care Plan
I documented **my** thoughts in my medical record	→	I **share my thoughts** with colleagues and patients in both written and verbal format
I coordinate **my** patient's care	→	**Our team works with others** in the Neighborhood to coordinate care
# of services **I** provide	→	# of people **we** serve
Decisions based on **quality and revenue**	→	Decisions based on **quality and cost** (charges)

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WMG PCMH: Striving for the Triple Aim

Behavioral Health Integration

Bridges to Health

Care Coordination Teams

Patient Partners Program

NCQA PCMH Recognition

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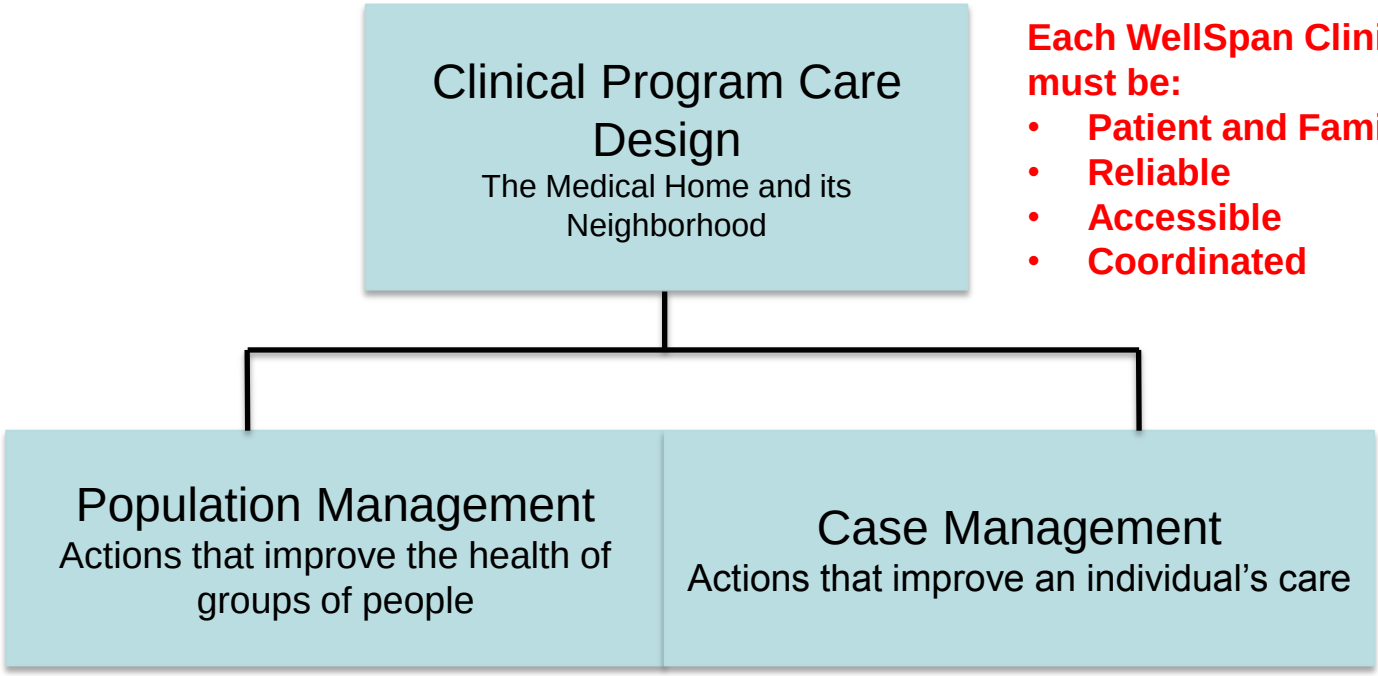
The AF4Q Collaborative and LIFT

(Learning Innovation for Transformation)

- AF4Q funded by RWJ Foundation
- 4th Year of PCMH Collaborative
- Monthly meetings
- WellSpan Medical Group and Private Practices
- Specialty AND PCMH around Neighborhood – planned for FY15

Care Management Functional Design

successful management *of the* ***health care needs*** *of* ***individuals*** *and* ***populations*** *to* ***improve*** the ***quality*** *and* ***manage*** *the* ***cost*** *of care*



Each WellSpan Clinical Program must be:

- **Patient and Family Centered**
- **Reliable**
- **Accessible**
- **Coordinated**

We apply these activities across the span of an individual's life from wellness through illness and injury, to death with dignity.

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Each PCMH has an embedded care management support structure known as a Care Coordination Team (CCT).

- **CCT Health Coach:** full time presence at the PCMH practice who helps patients
  - Contacts all patients discharged from hospital within 48 hours
  - Identifies high risk patients from a home-grown IT risk tool
  - Promote behavioral changes to improve their health

- **CCT Social Worker**: Shift their focus from hospital unit to PCMH practice
  - Based in the hospital, but has defined office hours in PCMH
  - Addresses financial issues that impact a patient's care decisions
  - Identifies and coordinates community resources
  - Area Agency on Aging Transitions program (Coleman model)
  - Assists patients with ***hospital*** discharge planning as well as support through the office setting

- **CCT RN Case Manager**: Shift their focus from hospital unit to PCMH practice
  - Based in the hospital setting but has defined office hours.
  - Identifying clinical resources to support the patient's goals for health.
  - Has an understanding of benefit plans, payer processes, and health care standards to help advocate for the patent's plan.
  - Nurse Practitioner Home visit program (Transitional Care Managers)

- **Successes:**
  - 70% Daily Huddles across 36 practices
  - 84% follow up appointment in 7 days for Medical discharges

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Working as One – Supporting the Patient

- East Berlin Family Medicine:
  - Discharge from hospital to home despite treatment team wanting placement.
  - Pt falling over the weekend - EMS put back in Bed.
  - Monday, CCT and practice facilitate SNF placement WITHOUT another hospital admission.
- Yorktowne Family Medicine:
  - Mom and Daughter urgent appointment;
  - daughter at wits end- unable to care for mom;
  - SW with daughter put together plan for community referral to SNF and Area Agency on Aging WITHOUT another hospital admission.

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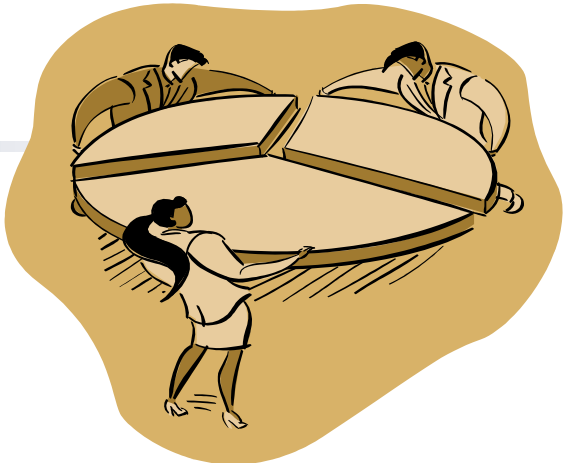
Patient Engagement: Shared Care Plan



Components:

- Care Team Members
- About Me
- Concerns
- Where I want to be /“life goals” for motivating better health
- Health log

Value:

- All members of the care team have a better understanding of patient
- All members of care team can work with patient towards attaining goals
- Primary and Specialty care providers have access
- Patient Portal Access

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Care Coordination Team Collaborative

- Agenda format- monthly video/ in person
  - Leadership presence
  - Bright Spots
  - Sharing of best practices
  - New Things
  - Team Time

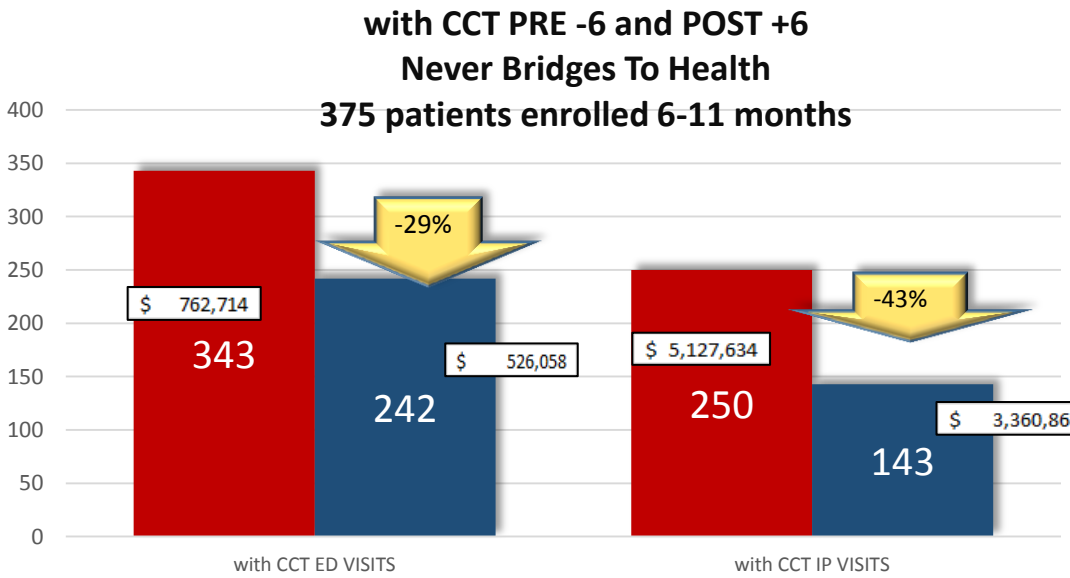
Bright Spots - 39

7	emphasized self-management/ engagement
10	involved rescuing the patient and family
2	involved coordination with end of life issues
16	involved coordination with community services with a wide variety in agencies- domestic violence services; housing, transportation, and Area Agency on Aging.
3	addressed gaps in care
1	focused on coordinating Patients goals with inpatient care

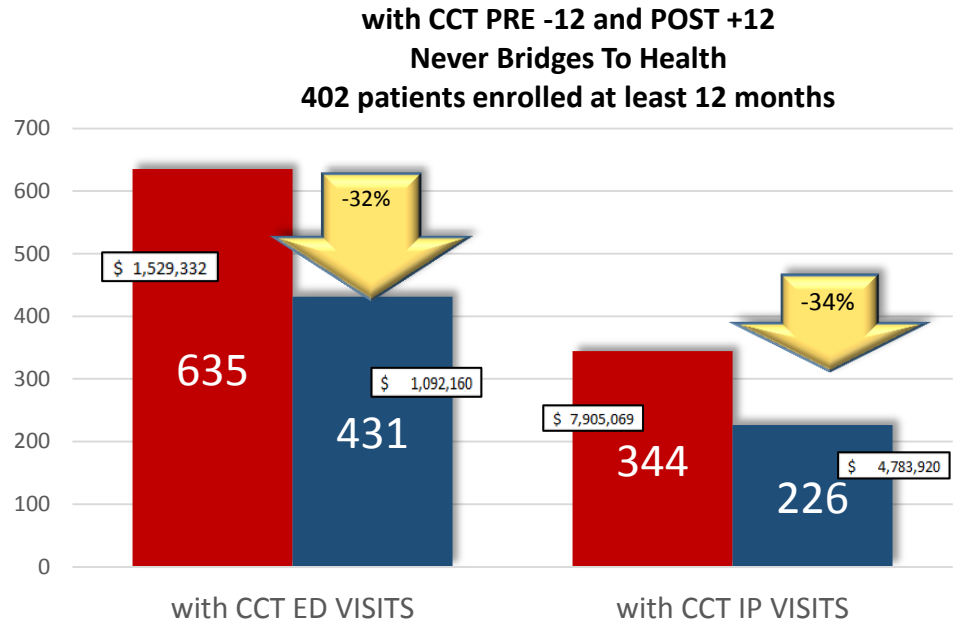
- Attendees: CCT team members; Health Plan Case Management; Wellness staff; PCMH patient partners, Transition Managers, Community Health Educators

- Collaborative:
  - Generates ideas/ focus areas like Behavioral Health
    - Led to pilot
  - Self management, Mental Health; Motivational Interviewing, Healthy Lifestyles, End of Life: POLST, Shared care Plan development

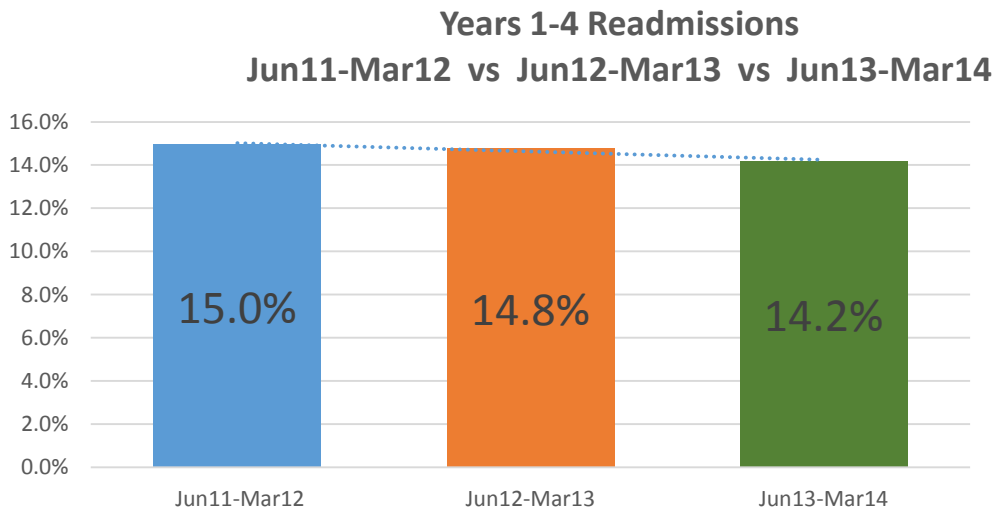
CCT Involvement Reduced ED and Inpatient Visits



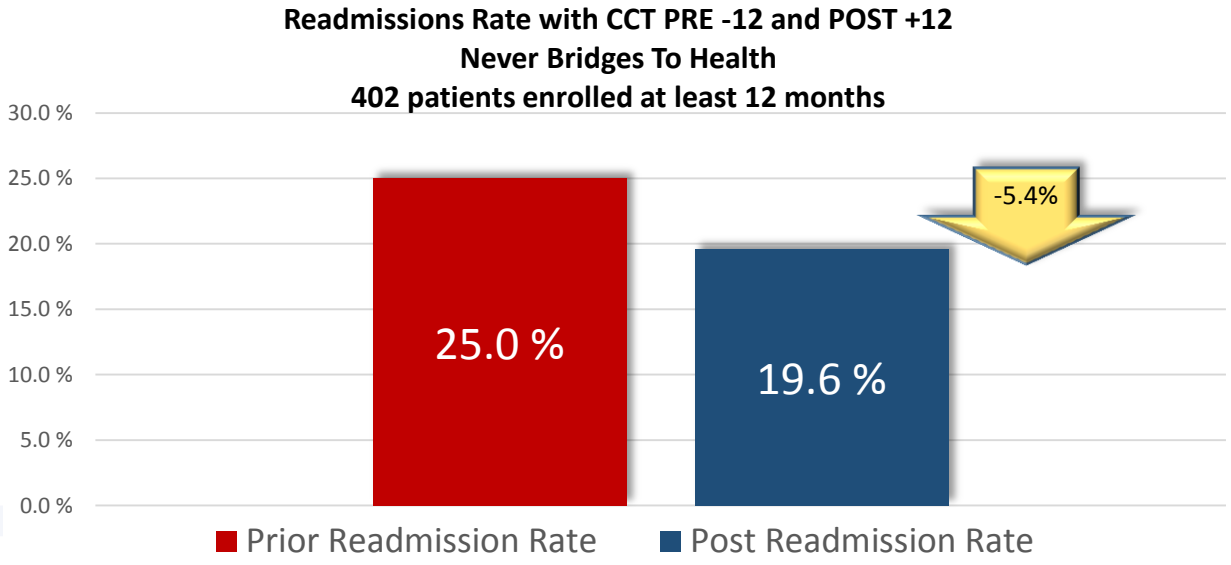
Long-term CCT Involvement Showed Further Reduction in Visits



PCMH Readmission Rates Declined



…Long-term CCT Involvement Showed Lower Readmission Rates



Patient Partners

- 2 patients per practice on the Quality Improvement Team
- Training/empowerment
- Monthly Patient Partners' meetings
- Join their practice leadership team for monthly meeting
- Now patient partners attend
  - Medical Group Quality Council
  - New Provider Orientation

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eCARE | Clinical Intelligence | Quality | WMG

WMG as of Apr-2014

Indicator Name	Drill to	Attained 2 stars	Score	Interim Target	Target (* benchmark)	Score Chart	Prior Period
Chronic Pain - CSA documented		★	58.02%	Met	* 50.00%		
Diabetes - A1c Control		☆	63.49%	67.79%	* 69.00%		
Diabetes - A1c Poor Control *(lower is better)*		☆	24.62%	20.78%	* 20.00%		24.71 %
Diabetes - BP Avoiding Poor Control		☆	69.09%	79.09%	* 80.00%		68.88 %
Female - Breast Cancer Screening			68.21%				
General - Advance Care Plan		☆	15.98%	24.59%	* 30.00%		
General - Colorectal cancer screening		☆	53.40%	64.82%	* 68.00%		52.90 %
General - Pneumococcal Vaccine for older adults		☆	84.39%	87.25%	* 88.00%		
HTN - BP Avoiding Poor Control		☆	61.92%	72.76%	* 74.00%		
Pediatric - Activity Counseling		☆	58.99%	62.63%	* 66.00%		58.86 %
Pediatric - Childhood Immunizations - Comb. 10		☆	43.11%	47.20%	* 48.00%		43.43 %
Pediatric - Record Smoking Status		★	77.05%	Met	* 77.00%		

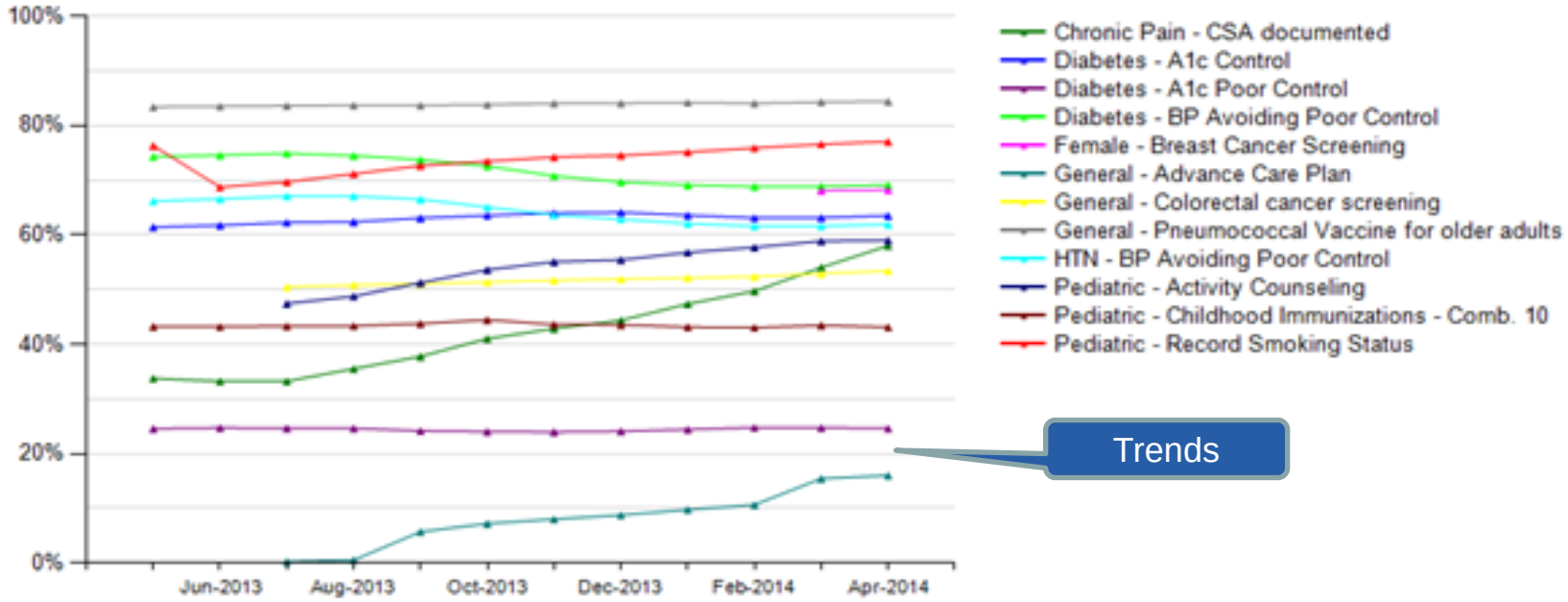
Indicators: Baseline | Score | Calculated Interim | Target | Benchmark

Star "awards"

Baseline

Pacer line

Target



Trends

eCARE Clinical Intelligence | **Quality**

Prev | Diabetes - LDL Current | Next

Practice	Drill to	Attained 8 stars	Score	Interim Target	Target (benchmark)	Score Chart	Prior Period	Missed Lives
	Diabetes - LDL Current as of Apr-2014							
GETTYSBURG ADULT MEDICINE		★	95.09 %	Met	90.00 %		94.86 % →	
DOVER IM		★	93.82 %	Met	90.00 %		93.59 % →	
BROCKIE IM		★	93.38 %	Met	90.00 %		93.75 % ↘	
THURMONT FM		★	91.95 %	Met	90.00 %		93.33 % ↘	
EAST YORK FM		★	91.27 %	Met	90.00 %		91.15 % →	
EAST BERLIN FM		★	90.02 %	Met	90.00 %		90.45 % →	
STONY BROOK FM		☆	87.84 %	89.97 %	90.00 %		88.34 % →	
GETTYSBURG FAMILY PRACTICE		☆	87.68 %	89.70 %	90.00 %		87.60 % →	
CROSS KEYS IM		☆	87.63 %	89.67 %	90.00 %		86.01 % ↗	
YORK HOSP COMM HLTH CTR		☆	87.06 %	89.84 %	90.00 %		86.61 % →	
SPRING VALLEY FM		☆	86.79 %	89.70 %	90.00 %		85.77 % ↗	
LITTLESTOWN FM		☆	86.67 %	89.31 %	90.00 %		84.46 % ↗	
YORKTOWNE FM		☆	86.66 %	89.70 %	90.00 %		87.15 % →	

Blue stars represent practices exceeding NCQA national top 10th percentile for measure.

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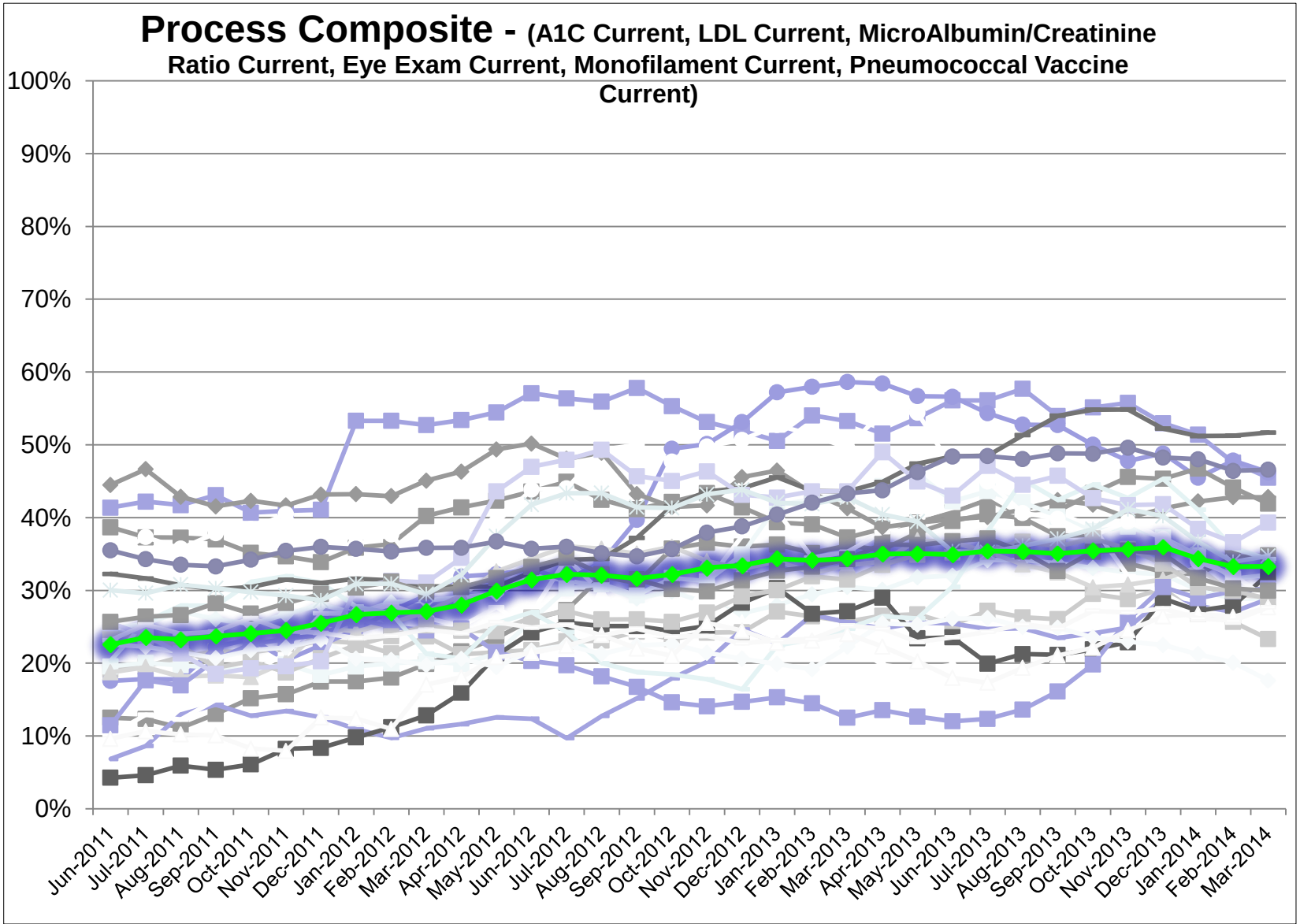
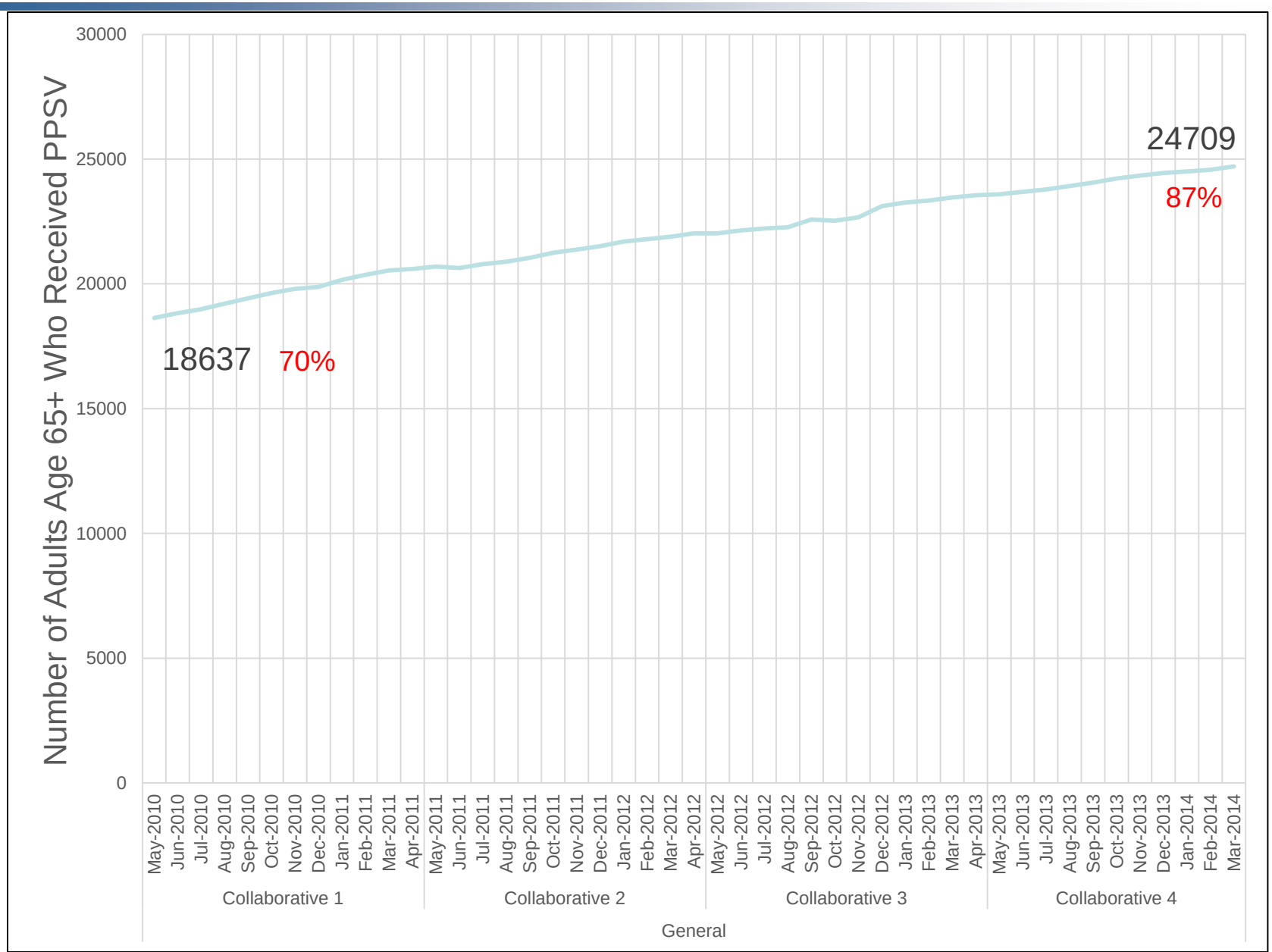
PCMH practices Have Changed Workflows That Improve Processes

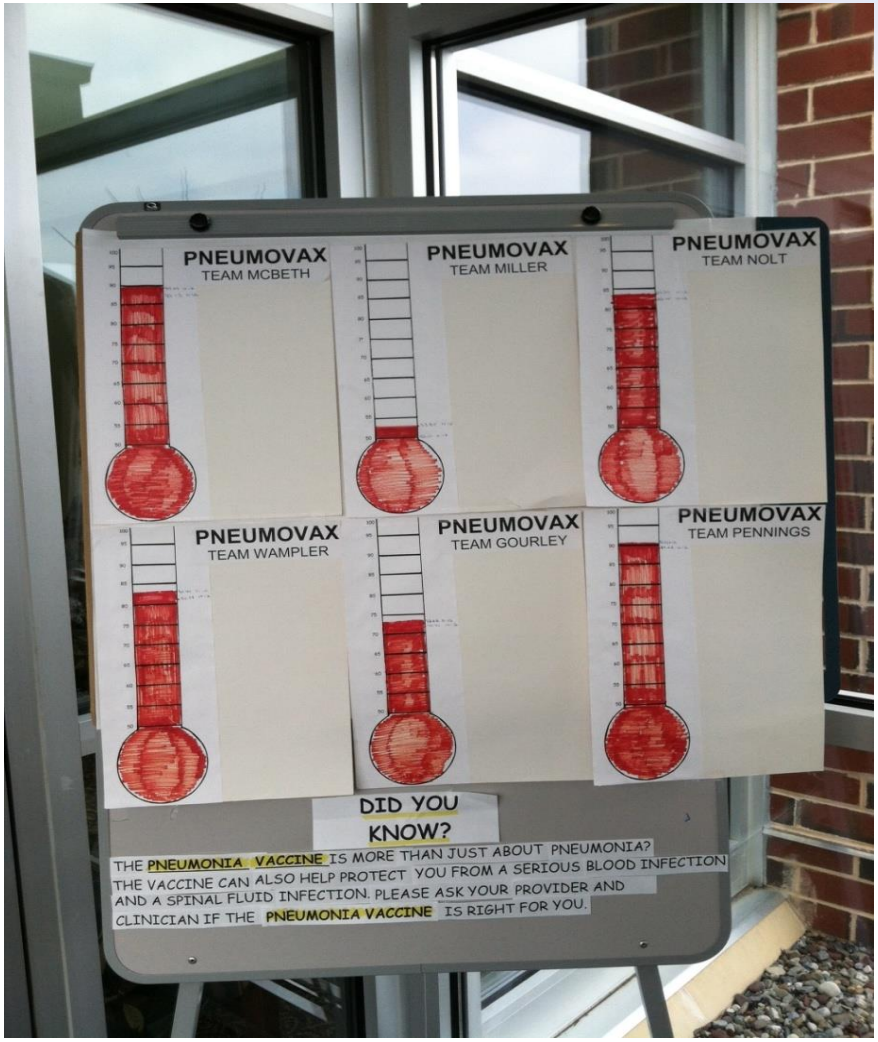


PCMH practices Prevented 18 Cases of Invasive Pneumococcal Disease

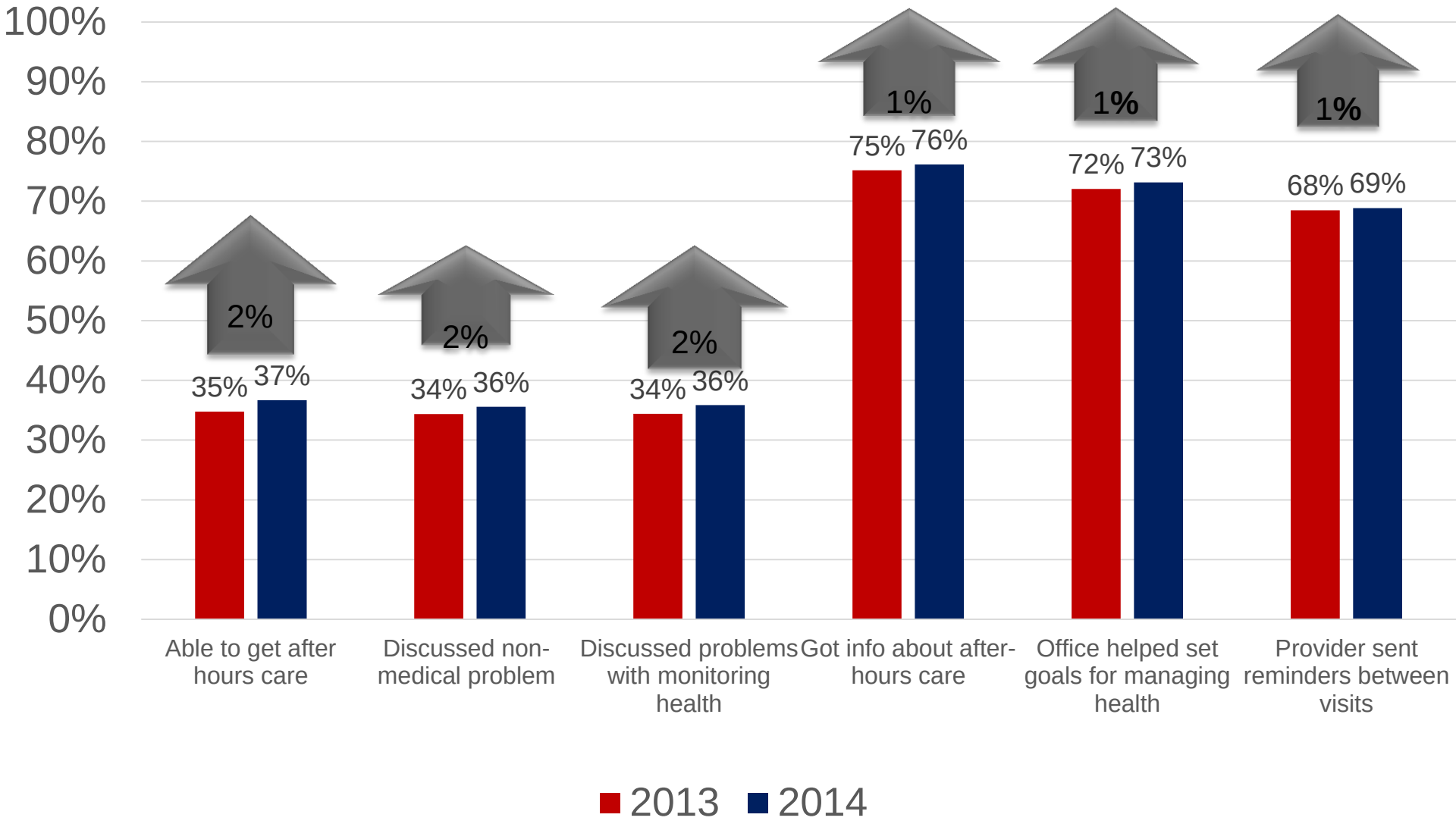


Aspers Waiting Room

Initiated by Patient Partner suggestion

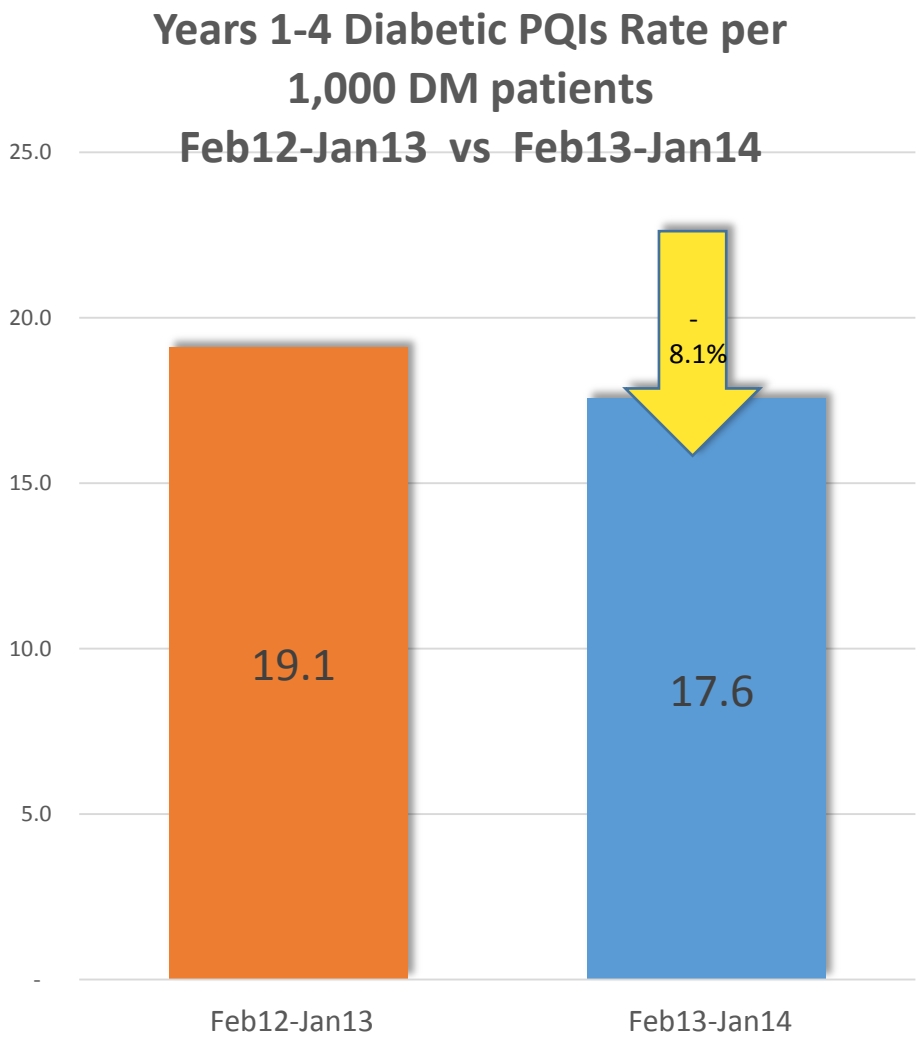


Year 1-4: PCMH CG-CAHPS PATIENT EXPERIENCE



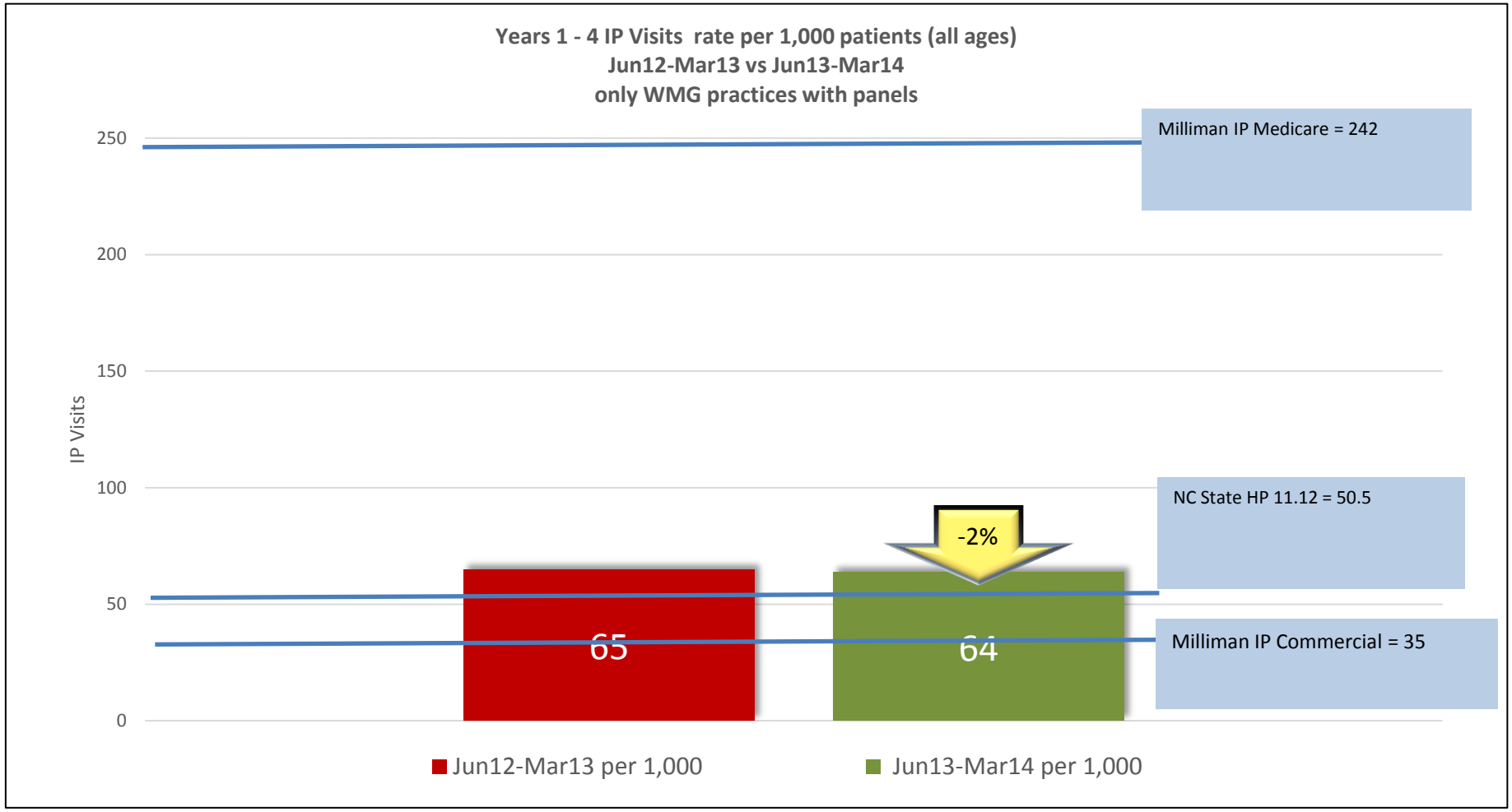
PCMH practices Prevented Diabetes Complications

- 1.8 Deaths related to diabetes
- 1.6 Fatal or non-fatal heart attacks
- 1.8 Amputations or deaths from vascular disease
- 8.4 Fatal or non-fatal microvascular disease
- 0.6 Episodes of heart failure
- 1.4 Cataract extractions
- Preventable Diabetic Admissions fell
- Poorly controlled A1c (>9) reduced from 27% to 23%
- Achieved despite 42 “new” Patients with Diabetes in the practice/month



The Agency for Healthcare Research and Quality (AHRQ) defines PQIs as ones for which good outpatient care could have potentially prevented the need for hospitalization or for which early intervention could have prevented complications or more severe disease. The diabetic PQIs include: short term complications, long term complications (including amputations), and uncontrolled glucose levels.

PCMH Inpatient Rates Went Down Slightly



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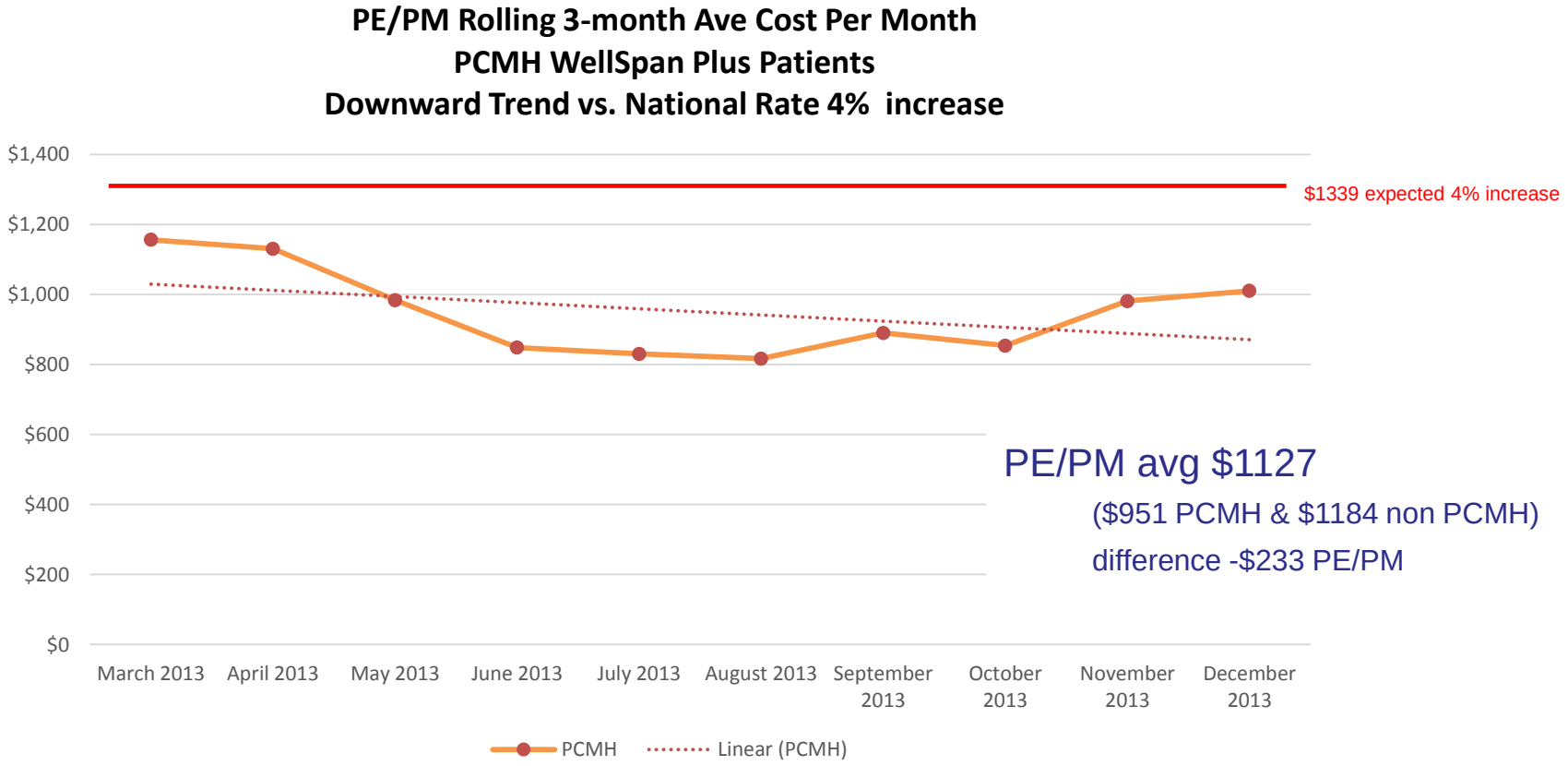
Costs for WellSpan Employees in PCMHs Fell



PE/PM avg $1127

($951 PCMH & $1184 non PCMH)

difference -$233 PE/PM

Note: The 2013 monthly average for eligible employees in PCMH=1,837 and Non-PCMH=5,537. The monthly cost for PCMH practices includes employee and spouse only.

Health spending growth through 2013 at 4%.
SOURCE: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group

PEPM= Per employee per month

WELLSPAN® HEALTH

SuperUtilizer Program: Bridges to Health

- September 2012
- Medical Director (PT), Physician (FT)
- Program Supervisor
- RN Care Manager (1:50), Social Worker
- Health Coach (LPN) and Medical Assistant
- Psychology Intern (“Behaviorist”)
- PT/OT attending care plan meetings and pts in office
- Access to through co-located practice
  - Dietician
  - Pharmacist
  - Financial case worker
- Center for Mind Body Health Collaboration
- Piloting College Intern (nursing first then psych/SW/pre-med)
- Soon: Embedded County Human Service Case Manager

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Bridges to Health (BTH)

- PCMH patients are invited to participate after primary care physician agrees to BTH intervention.
- PCP role is transferred to BTH for intervention period (typically 6-9 months).
- Focuses on soliciting patient goals, developing trust and empowering patient.
- Home visit as soon as possible – vital to understanding

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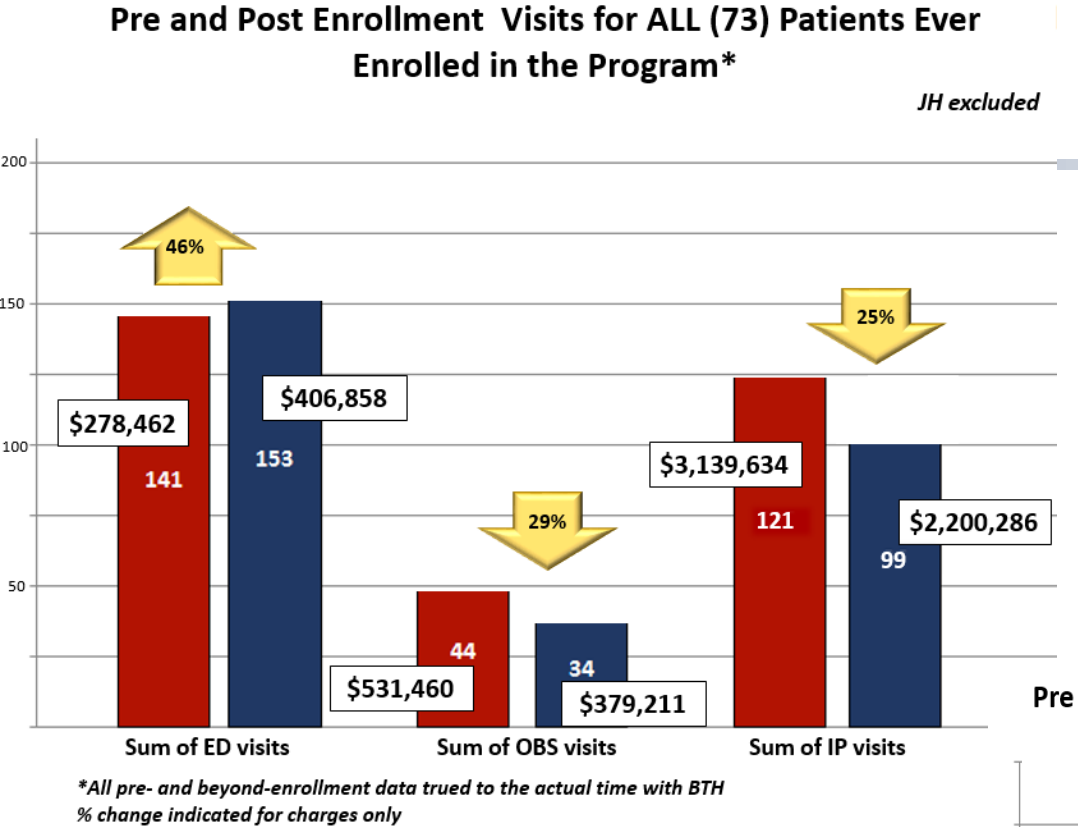
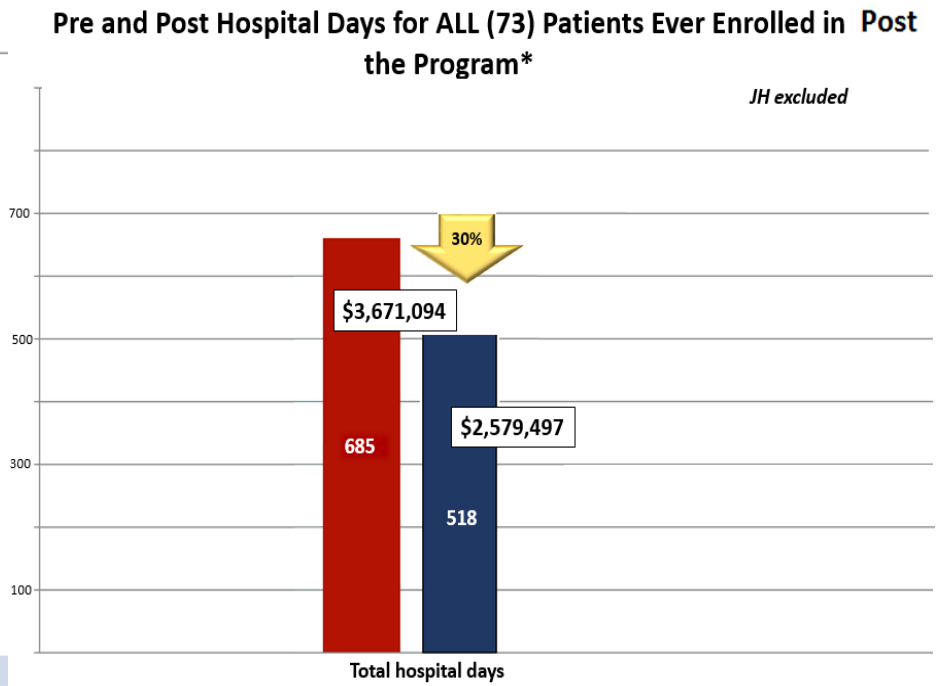
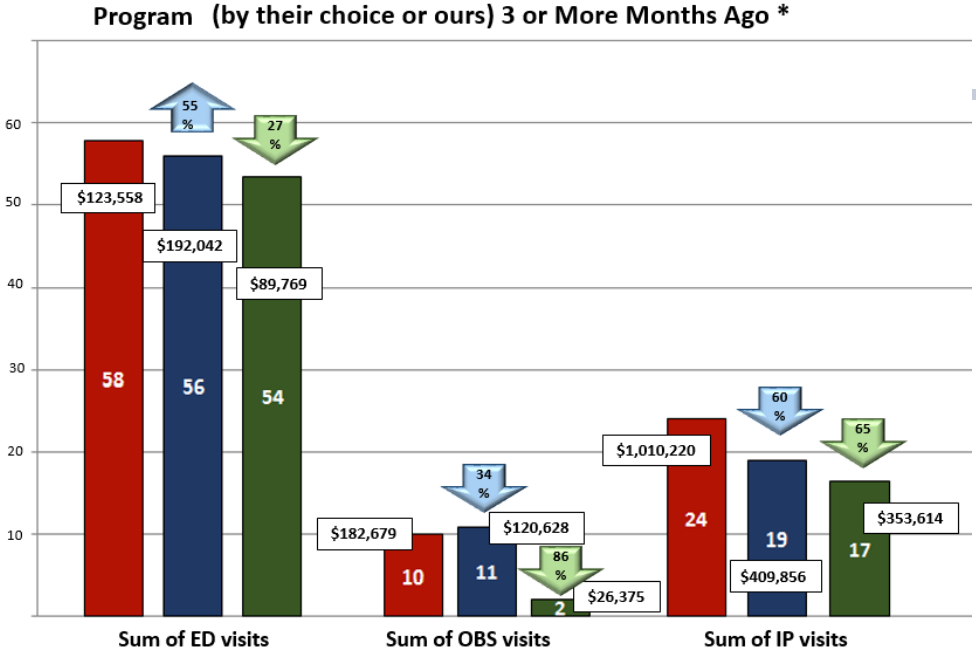




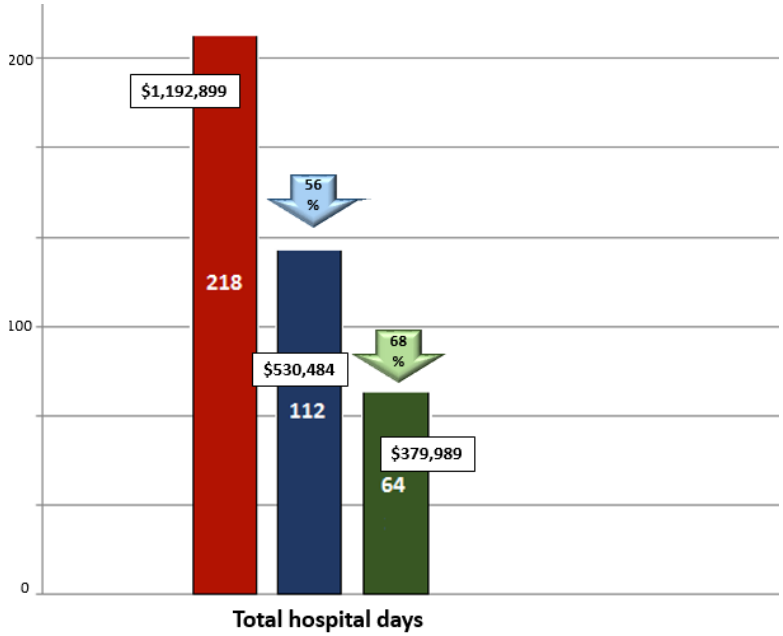
Bridges to Health to Date

Recruited since 9/17/12 = 92
Deceased = 5
Transitioned back to PCMH = 26
    Continue to track their utilization
Left Practice without organized transition = 4
Current enrolled = 55

Pre-, Post- and Beyond-Enrollment Visits for 15 Patients who Left the Program (by their choice or ours) 3 or More Months Ago *



Pre-, Post- and Beyond-Enrollment Hospital Days for 15 Patients who Left the Program (by their choice or ours) 3 or More Months Ago *



**All pre- and beyond-enrollment data trued to the actual time with BTH / % change indicated for charges only (Pre-BTH data used as benchmark)*
Only includes patients who remained active (alive) for 3 or more months after leaving BTH

AF4Q SCPA HighUtilizer Collaborative

- Learning Collaborative
  - WellSpan (RWJF)
  - Lancaster General
  - Crozer-Keystone
  - Pinnacle
  - Neighborhood Health Centers of the Lehigh Valley
- Facilitate statewide meeting
- Advocate for data sharing/funding pilots with Dept Public Welfare
- Highmark Foundation Grant
- White Paper – Combined Data

Pharmacy Role PPI Initiative

- **Opportunity:**
  - $900,000 by switching Brand to generic PPI for our employees/dependents
- **Interventions:**
  - Targeted letters to members highlight savings with PPI generics (to them)
  - Meet with Site Director and present “toolkit” containing:
    - List of patients taking a brand-name PPI (avg 8pts/practice)
- **Outcomes:**
  - Brand-name PPI prescriptions ***decreased >30% during 1st quarter CY14***
  - ***Associated savings >$24,000 in 3 months***

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Challenges and Next Steps

- Enhance the implementation of tools to aid the Case Management staff gain efficiency in their work process-
  - **EHR Case Management Module**
  - **EHR Readmission risk tool**

- Continue the transformation of primary care and pediatric care to Patient Centered Medical Homes and the development of Care Coordination Teams

- Case Management integration for Structure Interdisciplinary Bedside Rounding (SIBR).

- Continue to develop of the Patient Centered Medical Home team's coordination with Neighborhood specialty services.

WellSpan® HEALTH

Sustainability……

Direct Revenue

- Care Coordination E&M code ***annualized payment*** $ 585,000
- TCM Program 1/3 – ½ capacity
  - Billed ***annualized (56% collection rate)*** $ 80,000

Revenue Total: **$ 665,000**

Cost Avoidance (* Based on average case rate $6200)

- Reduce Preventable Hospitalizations-
  - Reduced DM PQI from 19.1 to 17.6 =20 visits *$ 125,000
  - Avoided Invasive Pneumococcal Disease= 18 *$ 111,600
  - Bright Spots avoided hospitalization (26) *$ 161,200
  - Bridges to Health avoided 22 IP visits for all BTH pt.s *$ 136,400
- WellSpan Employee cost savings** *based on cost trend for WellSpan Plus*
  - Attributing for ½ the difference in PCMH PE/PM savings (-$233) $2,568,126
  - Pharmacy PPI initiative $24,000/ quarter ***annualized*** $ *96,000

Excludes Utilization trends (CCT)

Avoidance Total: **$3,198,326**

Questions?

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