Primary Care: Leading Health System Transformation through Team-based Care Delivery

July 2014
Agenda

I. Context for Change & Importance of Team-based Care Models  
*Melissa McCain*

II. Case Study: Cone Health – Project Restore the Joy  
*John Jenkins, M.D.*

III. Case Study: Carolinas HealthCare System – Patient First Initiative  
*Zeev Neuwirth, M.D.*

IV. Q&A

*Please note that the views expressed by the conference speakers do not necessarily reflect the views of the American Hospital Association and Health Forum.*
For the last three years, leading organizations have prepared for the new value-based environment by aggregating and aligning resources. Activation is now required to create the value desired by the organization and their patients, and required by payers and employers.

Drivers of Competitive Advantage

1. **Aggregate**
   - Health system assembles the delivery network to create economies of scale and expertise
   - Unprecedented levels of hospital & physician accretive activity

2. **Align**
   - Health system and physicians establish vehicles that align them clinically and economically
   - Common economic platforms and organizational governance

3. **Activate**
   - System creates value by adopting a singular model for managing inputs, delivery, and organization of services across the entire continuum of care
   - Demonstration of value through the seamless cross-continuum care of an integrated model
Clinical Transformation: A Thoughtful Approach to Value

Organizations must reinvigorate efforts to ensure superior foundational clinical management which is required to support more advanced clinical management and population health management.

**Foundational Clinical Management**

**Advanced Clinical Management**

**Population Health Management**

**Near-term Strategies**
- Support Financial Success Today and Build Foundation for Future by Site of Service
  - e.g., consistent care processes and roles by site of service, access and throughput, capacity management
- Demonstrate Value for Select Segments
  - e.g., complex case and chronic disease management

**Long-term Strategy**
- Demonstrate Value by Managing All Aspects of Health and Care for At Risk Population
  - e.g., wellness and prevention
What is the Best Role for Primary Care?

Primary Care as …

“Condition Neutral” Patient-centered Medical Home

Transitions Manager

Part of Medical Neighborhood

Population Health Manager

Health Promotion

Complex Care Coordinator

Integrator with Behavioral Health

“Intensivist” Patient-centered Medical Home
Clinical Transformation: Mixed Messages

What is the Best Role for Primary Care?
Clinical Transformation: Mixed Messages

Weeding through the mixed messages regarding the future of primary care is challenging …

- What is really needed of primary care to meet patients’ needs?
- What role does primary care play as part of a broader system of care?
- How does a team-based primary care model drive transformation?
- What might a value based roadmap look like to guide change?
Primary Care: Relevance in a Value-Based Environment

What we do know is that Primary Care plays a dramatically expanded role in determining the financial success of health systems transitioning to value-based care.

<table>
<thead>
<tr>
<th>Role in System</th>
<th>Fee-for-Volume</th>
<th>Fee-for-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Low-priority, low-margin source of referrals for specialty care</td>
<td>Coordinate care across the continuum of care; patient attribution models often driven by primary care</td>
</tr>
<tr>
<td>Financial Impact</td>
<td>A single primary care physician provides $1 million in downstream revenue for hospitals</td>
<td>A single primary care physician controls $12-14 million in total healthcare expenditures</td>
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</table>
Moreover, leading organizations often use Primary Care transformation to signal the broad cultural and operational changes required by the transition from volume to value.

Requires physician leadership that engages and develops clinical leadership

Addresses core competencies of value-based care (e.g. team-based care, access, care management, etc.)

Drives cultural changes which are visible throughout the organization
Primary Care: Increasing Importance

However, broad trends in care delivery suggest growing challenges for the existing primary care system to provide adequate care at a time when its importance to health system is growing.

1. Mismatch of Supply and Demand

   - **Increase in Demand**
     - ACA has increased insured population
     - Aging population increasing demand for chronic care management
   
   - **Decrease in Supply**
     - Fewer medical students entering primary care
     - Primary care providers leaving field mid-career

2. Shift in Care Settings

   - Care delivery and profitability shift from inpatient to outpatient settings
   - Primary care physicians exert increasing influence over ambulatory referrals and related diagnostic and ancillary services
Primary Care Transformation

**Access**
- Same-day access
- Appropriately utilized capacity
- Growth of panel size
- Better work flow by design

**Care Team**
- Teams working at top of skills
- Expanded roles
- Options to reflect varied nature of practices
- Better work flow by design

**Coordination**
- Information sharing
- Improved access to support transition care
- Teams working at top of skills

**Reliable Care**
- Best practices/Standard work
- Better work flow by design
- Teams working at top of skills
- Informatics to support decisions

**Patient-Centered Care Model**
The details of, timing, and sequencing of primary care development approaches will vary based on organizational characteristics.

**Roadmap Development**

**Current State**
- Independently-Operated, Uncoordinated Practices

**Future State**
- Optimized Primary Care Model
  - Patient-Centered Care Model
  - Reliable Care
  - Care Team
  - Access
  - Coordination

**Transformation Roadmap**
- Pace of Change
- Sequencing of Solutions

**Influencers**
- Physician Platform & Alignment
- Available System Resources
- Size & Scope of Payer Contracts
Primary Care Transformation Driven by Care Teams

The objective is to outline a framework for thinking about care teams – not a rigid single system that may feel too restrictive to individual practices

Principles and Concepts for Care Team Redesign

- Clear role delineation, education and development for each member of the care team that permits them to work to the full scope of their license/practice;
- Trust and respect among care team members and an environment that supports sharing points of view and collaborating in order to deliver the optimal care to the patient;
- Team roles that can expand and/or be modified to fit the specific characteristics and needs of the population being served;
- Use of different care team members suited to manage patient needs; and
- Accountability of all practitioners to the team and the patient.
Patient First Team Care Model

Cone Health
Cone Health has served the health needs of the Greensboro, NC, community for over 60 years

- 6 hospitals, 3 medical centers covering 5 Counties
- 199 physician practice sites
- 1,300 physicians, including more than 300 employed physicians and 800 aligned physicians in a Clinically Integrated Network
- Largest Regional ACO in NC with over 40,000 covered lives
Transformation of Care Delivery

Design is one of the most powerful ways to effect behavior...

We do not design for who we are but who we wish to be.

Lorna Ross Director of Design at Mayo Clinic Center for Innovation
Core Components of Primary Care Transformation

CUSTOMER CENTERED CARE MODEL

Access

Care Team

Coordination

Reliable Care
The Current State is Unsustainable

- The primary care provider is increasingly overwhelmed with the “how” of practice and can no longer feel the “why” of primary care.

Primary care practitioner practices with a panel of 2,000 or more patients per full-time practitioner are unable to provide accessible high-quality care to all of their patients. A primary care physician with an average panel of 2,000 patients would spend 17.4 hours per day providing recommended acute, chronic, and preventive care. Institute of Medicine Report Oct 2012
Five Secrets of High Functioning Primary Care Practices

1. Proactive “pre-visit” planning
2. Shared clinical care in a team model
   ▪ Expanded rooming protocols
   ▪ Standing orders
   ▪ Panel management protocols
3. Collaborative documentation
   ▪ Shared/ delegated clerical tasks
   ▪ Non-physician order entry
   ▪ Streamlined prescription management
4. Improved communication
5. High level team functioning
   ▪ Co-location, team meetings
   ▪ Workflow mapping for efficiency

As published in the Annals of Family Medicine Vol. 11, May/June 2013
Current State

• Our current model is a “lone provider” with “helpers”.

  Provider has sole responsibility

• Possible Solutions?
  – Add “helpers”? 
  – Reduce slots? 
  – Refer out patients? 
  – Use Vendors?
The Future of Primary Care is a “WE” proposition

- **Shared** responsibility
- **Meaningful** **team** contributions
- **Team** goals and **team** results
- **Standard** work flows and efficiencies
- Standing orders for “**best practices**”
- Pre, during, and post visit planning process
To Get to That Future We Need To:

• **Delegate** work that does not require profession training

• Develop **standard pathways** for preventive services and chronic care needs

• Move these services **outside** of “visit time”

• **Advance CMA team members** to become flow managers and health coaches.

From *Core Principles and Values of Team-Based Health Care*  IOM Roundtable
True North Metric: Are We Adding Value for Our Patients?

Culture is the aligning force that allows us to effectively use process improvement to transform the way we work.
Work Flows Identify Value

Value Stream Mapping (VSM)

- Lean Technique used to visualize waste in a process
- By direct observation of people doing the work in the actual workplace
### Before The Visit
- Visit purpose capture
- Helpful staff
- Appointment availability
- Accurate data capture/transfer
- Visit expectation setting
- Patient needs assessment

### Pre-visit Planning
- Agenda setting
- Pre-visit orders driven by best practices and patient needs
- Medication management needs identified
- Pre-visit information provided
- Patient education identified and planned

### During the Visit
- Attentive staff
- Minimal additional paperwork
- Technology based check-in
- Short wait times
- Patient updated on providers' on-time status

### After the Visit
- Seamless hand-off between care team members
- Enhanced CMA roles
- Collaborative documentation
- Provider created assessment and plan
- Enhanced scribing function

### Between Visits
- Follow-up visit scheduling
- Complete plan by placing orders
- Referral management
- Test results through MyChart
- Care escalation
- Patient engagement for plan adherence
- Care Coordination
- Transitional visits
- Patient's roles + responsibilities

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**Value Added to Each Phase of the Visit Cycle**

<table>
<thead>
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<th>During the Visit</th>
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<td>Visit Scheduling</td>
<td>Check-in</td>
<td>Visit</td>
<td>Follow-up</td>
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**Care Team Members Working to the Top of Their Skill Set with seamless hand-offs**
3-Step Detailed Flow for a 30 min “Chronic Disease Management” Team Care Visit

15 MINS
CMA rooms the patient and follows **Standard Work Stream** for data collection.
(reason for visit, health maint./preventive services, med rec, ROS data, and patient prep)

10 MINS
Provider enters the room. CMA reports data collection. Provider completes CC / HPI.
The provider’s HPI, exam, assessment and plan is documented. The plan is then “handed off” to the CMA for execution.

5 MINS
CMA executes the plan. If parts of the plan require a higher level of care, the CMA **escalates the plan to proper team member**.

The provider’s cycle is 10 min FTF and 5 min for desktop in-between each visit cycle. The CMA remains in the room with the patient for the entire 30 min cycle. The RN floats between 4 providers. Plan “escalation” to proper team member occurs due to patient care or flow needs. Other team members? Case management, SW, and pharmacy?
Expanded CMA Role

**Work Stream Development:**
1. Patient rooming and agenda setting
2. Document **Reason for Visit**
3. Pre-Visit information loading “preloading”
4. Vitals (and smoking, weight, height, etc.)
5. Health Maintenance/Preventive Services/Best Practice Alerts
6. Med Rec
7. Complete data collection for active problems (driven by Reason for Visit)
8. Review ROS for “red flags” and close any final care gaps
9. Physical preparation of the patient for examination or procedure

Process development is informed by sequential EMR flow, time restraints, and training competencies.

**NEW Major Skills:** Data collection and identification of “red flags”
Measuring Success: True North Metrics:

The Fundamental Concept of Standardized Work:
If there is no standard to measure against, how do we know we are truly getting better?
Process Roadmap for Practice Engagement

Discover

1. Envision Your Future
   - Event to present Roadmap and assess interest

2. Cultural and Functional assessment
   - Using “5-D” tool and
   - Teamwork readiness survey to assess practice readiness

3. Commitment plan
detailing the time and costs and reviewing ROI

4. Sign “compact”

Prepare

1. Team Preparation
   - Staffing (talent acquisition)
   - Process (Lean) Training

2. Plan Preparation
   - Value stream mapping (gap analysis)
   - Launch event
   - A3 (problem defining)
   - RIE preparation: process ownership and team selection, goal selection and data collection

Transform

1. Process deployment
   - RIE events to create standard work for the visit cycle
   - Daily Huddle training
   - MDI training
   - Weekly Improvement meeting and visual management training

2. Real time practice
   - (test the model)

3. Measure and report success

4. Ownership of process transfer
Keeping the Process Going

- Daily Huddles
- Teach every team member how to solve problems (MDI)
- Weekly progress meetings with Visual management
- Continuous Product Improvement
- Embed Innovation
Next Steps for Patient First Care Design:
Is There an Even **Larger** Vision?

Can we develop programs across **Cone Health**
to promote population management?
The Future : The Center for Ambulatory Care Transformation

- Lean based transformation of all ambulatory care
- Transitional care innovation
- Virtual Visits
- Deployment of RNs, pharmacists, and APP’s
- Strategic Partnerships
- Centralized Patient Engagement Services
- Purposeful design for the use of “Decision support informatics”
Patient First – Primary Care Initiative

Carolinas HealthCare System
VISION
Carolinas HealthCare System will be recognized nationally as a leader in the transformation of healthcare delivery and chosen for the quality and value of services we provide.
Our Goal: to be ‘Better Together’
Integration & Alignment
Standardization
Physician Engagement & Leadership
Coordinated, Efficient & Effective Execution
Patients First
Primary Care Initiative

Develop an Ideal State -
“The CHS Way” -
for an integrated
Primary Care
organization that
reflects the shift to
value-based care

Build enthusiasm
and momentum with
a critical mass of
CHS thought leaders
and clinical leaders to
ensure sustainability of the
transformation
Project Structure

**EXECUTIVE SPONSOR**
Dr. Zeev Neuwirth

**EXECUTIVE OVERSIGHT COMMITTEE**
Paul Franz, Zeev Neuwirth MD, Joe Piemont, Roger Ray MD

**Operations Oversight Team**

**Workgroups**
- Clinical Care Model
- Clinical Operations
- Value-based Sustainability
- Organization & Governance Structure
- Metrics & Measurement

**Integrated Project Support Team**
- Chartis Team
- Operations Rep(s)
**Patients First** Primary Care Clinical Pillars

**Convenient Access**
- Broader incorporation of ACPs
- New types of encounters: e-visits, telephone visits, virtual medicine
- Schedules with open (same day) access

**Value-laden Encounter**
- New Care Team model with each team member working at top of skill level
- Standardized workflows and roles
- Provide leverage for physicians (i.e. flow manager)

**Customized Coordinated Care**
- Integration of care and case management
- Integration of big analytics to identify high need patients
- Integration of Behavioral health

**Reliable Clinical Care**
- Easy access to evidence-based medicine in practice and EMR
- Timely access to performance information
- Non-punitive monitoring of performance
In a value-based environment, priorities shift and definitions of success change. CHS will need to focus attention on new and different competencies in order to maintain high levels of performance.

**Value Map:** CHS Primary Care Performance vs. Future Market Priorities

**New Definitions of Volume and Cost:**
- Volume and Market Share will always be important, but will be expressed by number of patient lives being managed as opposed to number of patient visits.
- Cost definition will be expanded to Price (for patients and payers) in addition to unit cost (i.e. internal cost structure).

**Source:** Patient First Value-based Sustainability Workgroup
New Models that Enhance Access

**SHARED MEDICAL APPOINTMENTS**
Extended 90 minute visit with their provider.

**MYCAROLINAS PATIENT PORTAL**
- Manage your appointments
- Communicate with your doctor's office
- View lab or test results
- Renew prescriptions
- Manage your child’s health
- Pay bills and much more

**PREVENT**
16-week online program that uses Diabetes Prevention Program curriculum coupled with digital tracking tools, personalized coaching, and social support

**E-VISITS**
Provide patients with rapid triage and treatment via portal functionality and tools

**YMCA LIVEWELL CENTERS**
First in the Nation - EMR Connectivity between YMCA and Medical Home
Creates community extension of the PCP and Primary care clinical teams

**TRANSITIONS**
Provides ‘transition bundle’ for high risk patients
Using “teach back” Call-back phone # for urgent calls instead of EMS call or UC

**ADVANCED CLINICAL PRACTITIONERS**
Center for Advanced Practice Primary Care Tracts
Sample Standards for Same Day Access

- All providers have same day access with a
- Minimum 20% practice template same day access
- Minimum practice coverage at any given time
- Easy & Open access to hospital follow-up visits
Clinical Care Team: Redefined & Skill Optimized

From This Traditional Model …

**Provider/Physician**
- Diagnosis/Treatment
- Documentation
- Messages/Inbox management
- Health Maintenance/Screenings

**RN / LPN / Clinical Assistant**
- Rooming Patients/Vital Signs
- Vaccine/Med Administration

…To a Fully Realized Medical Home Model

**Physician/Provider**
- Diagnosis/Treatment
- Management of Higher acuity pts
- Supervision of ACP & Team

**RN**
- CDM Standing Orders
- Patient Education
- Care Management
- Triage

**Clinical Assistant/Flow Manager**
- Standard Rooming Protocol
- Pre-Visit Planning
- Panel Management/Prevention

**Health Advocate (New Role)**
- Goal Setting
- Transition Assistance

One
Carolinas HealthCare System
Care Redesign by Population Segment

High Risk
- Advanced Illness Management
- Transitional Care Management

Rising Risk
- Diabetes Care Management
- Diabetes Prevention Program
- Medication Titration Clinics

Well
- Reminded Care
- Navigation Line

• Readmission Reduction (*Predixion*)
• Emergency Department visit Reduction (CCNC)
• Transitions Care Management Discharge Phone calls

• Disease Management THS: ESRD, HF
• YMCA Medical Referral- Canopy implementation
• Health Coaching and Health Advocate roles developed
• Diabetes Prevention Program training/Master Trainers
• Ambulatory Care Mgmt / Diabetes Care Protocols
• PharmD Diabetes Insulin Titration Protocols
• Identification of high risk Diabetics (Humedica)
• Asthma registry including enhanced Asthma Action Plan with embedded decision support
• Shared Medical Appointments  Chronic Disease Mgmt
• Canopy Registry Work lists- Ambulatory

• Reminded Care- Expanded Identification of Care Gaps
• Customer Relationship Management Implementation
• My Carolinas Patient Portal
• Canopy Point of care reminders for preventive/overdue services

Carolina HealthCare System
400+ Front Line Providers & Staff Representing 132 Primary Care Locations Over 26 Rapid Improvement Events
VALUE LADEN ENCOUNTERS
Medical Home 1.0 Pilot

400+ Front Line Providers & Staff Representing 132 Primary Care Locations
in over 26 Rapid Improvement Events

Before The Visit
- Pre-visit Planning
- Daily Clinical Huddle

During the Visit
- Rooming POCT
- Visit

Between Visits
- Lab Tracking Flow Mgr
- Registry Management

ED/Hosp F/U
- Coordinated for PCP Appt
- Care Gaps
  identified prior to visit
- High Risk Pt Med Rec

Point of Care Testing
- 60% ↓ in Cycle Time
- Health Maintenance Alerts
  ↑ 50% to 85%
- Proposed orders: 200 dy

Lab Tracking Cycle Time
- ↓ 13 min/Provider/Day
- Real time in box resolution
- Care Gaps
  Closed Between Visits
Care Model Redesign “Standard Work” Modules

The objective of each component/phase of the Care Model Redesign is to reduce variation, optimize performance, and improve the experience.

“Standardization” (required for improvement)

Access, Panel Management

Rooming, Exam

Revenue Cycle, Referral Management

Call Management, Scheduling

Management for Daily Improvements

Inventory/Supply Management

Pre-Assessment

Pre-assessment criteria has been developed for each “change module”

Metrics & Tracking

Ability to measure performance is critical for success
Creating The Standard
132 Primary Care Practices in 24 Months !!!

Module | Implement | Standard Work
---|---|---
Access & Panel Size | 90 Days | Patient Contact Hours Per Day/Week
Management for Daily Improvement | | Preventative & Same Day Visit
Inventory Mgmt & Medication Prep | | Live Answer & Triage
Scheduling, Revenue Cycle & Care Coordination | | Supply & Demand Planning
Rooming & Exam | | Payer Agnostic

90 Days

Metrics & Measurement
Improve Staff Engagement
Culture of Accountability

10 Days

Medication and Vaccine Administration
Inventory & Supply
Patient Safety

10 Days

Pre-Arrival/Check-in/Check-out
Template Management
Hospital Transition Appointments
Referral Management
Patient Portal

Visit Readiness
Care Gap
Skill Optimization
Coding & Charge Capture
# Care Model Pilot
## Lincoln Family Practice Pilot Results

<table>
<thead>
<tr>
<th>Metric</th>
<th>Description</th>
<th>Baseline</th>
<th>Actual</th>
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<tbody>
<tr>
<td>Health Maintenance Task Completion</td>
<td>% of Current Alerts Satisfied</td>
<td>50%</td>
<td>84%</td>
</tr>
<tr>
<td>Patient Thru-put</td>
<td>Avg. # of Patient Office Visits</td>
<td>25</td>
<td>33</td>
</tr>
<tr>
<td>Patient Satisfaction</td>
<td>Likely To Recommend</td>
<td>80%</td>
<td>95%</td>
</tr>
<tr>
<td>Cycle Time</td>
<td>Minutes (IDX)</td>
<td>59:00</td>
<td>52:00</td>
</tr>
<tr>
<td>Provider Workday</td>
<td>Hours</td>
<td>10:00</td>
<td>9:00</td>
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<tr>
<td>POCT Cycle Time</td>
<td>From Order to Result</td>
<td>13:06</td>
<td>05:12</td>
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<tr>
<td>Messaging</td>
<td>Time to Answer Messages</td>
<td>4:00:00</td>
<td>0:30:00</td>
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Notes:
1. CPOE: As a result of the efficiency and balance of provider cycle time to scheduled patient time, CPOE accuracy issues are insignificant.
2. Staff Satisfaction: Given the greater utilization and training of clinical staff as care team members, their satisfaction has increased.
Diabetes Control

CHSMG
90%ile**
75%ile**
50%ile**

Favorable
Ambulatory Appropriate Care

- Actual: 83.4%
- Target: 82%
- Stretch: 85%

Bar Graph

- DIABETES
- ASTHMA
- HEART FAILURE
- ISCHEMIC VASCULAR DISEASE
Carolinas Healthcare System Medical Group

Reorganization

1. “Patients First” Orientation

2. Supportive & Meaningful Environment for Clinicians & Staff

3. Organizational Stewardship

4. Transformative - Creating the Future of Health Care
<table>
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<tr>
<th>CHS Medical Group Council &amp; Committees</th>
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<tr>
<td>Each Group Lead by <strong>Dyad Team of Physician and Administrative Leaders</strong> with <strong>Appropriate System Resources</strong> to Support Efforts</td>
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</tbody>
</table>

| Executive Council | Governance  
|                  | Transmit Strategy  
|                  | Deploy Goals & Tactics  
|                  | System Initiatives  
|                  | Communications  
| Finance/Metrics Committee | Finance  
|                  | Payor Contracting  
|                  | **Physician Compensation**  
|                  | Coding/ICD10  
| Quality Committee | Quality Goals / Performance  
|                  | Care Protocols  
|                  | Patient Safety  
|                  | Canopy  
| Care Delivery Operations Committee | Patient Experience  
|                  | Standardized Work  
|                  | Access  
|                  | Medical Home Deployment  
| Leadership & Professionalism Committee | Physician Orientation  
|                  | Physician Retention  
|                  | **Leadership Development**  
|                  | Social Compact  
| Care Redesign Committee | **Care ReDesign Focus:**  
|                  | Skill Optimization - ACP Model  
|                  | Health Coaching & Advocate  
|                  | Virtual Care- TeleMedicine  
|                  | EBC Protocols/Guidelines  
|                  | Indigent Care  
| Academic Committee | **Academic Integration**  
|                  | Research & Teaching  
|                  | Acad. Dept. Model Deployment  
|                  | Academic Finance & Funds Flow  

Each Group Lead by **Dyad Team of Physician and Administrative Leaders** with **Appropriate System Resources** to Support Efforts.
CHS Medical Group 2014 Focus
(‘Must Do’s/Can’t Fails’)

- ACCESS & CONVENIENCE
- STANDARDIZATION (Quality, Cost, Experience, Brand…)
- MEDICAL HOME 1.0 DEPLOYMENT
- COMPENSATION ALIGNMENT
- LAUNCH ‘PATIENTS FIRST’ SPECIALTY DIVISIONS
- QUALITY OF CARE
VISION

Carolinas HealthCare System will be recognized nationally as a leader in the transformation of healthcare delivery and chosen for the quality and value of services we provide.