A New Approach to Patient-Centered Procedural Care

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Agenda

1. Background
2. The Patient Journey at Partners HealthCare
3. Progress to date
4. Key program elements
5. Redesigning prior authorization
5. Emerging lessons from the front line

Please note that the views expressed by the conference speakers do not necessarily reflect the views of the American Hospital Association and Health Forum.
Imagine you are a patient and you might need surgery...

How would you know which hospital to select?

Or which doctor to choose?
When making a decision...

What drives your decision?

How would you make an informed, data-driven decision?

Talk with your provider, family, & friends

Google
Optimizing the decision phase of the Patient Journey

- **Data-backed insights**

- **Optimal Decision Making Environment**

- **Physicians Knowledge & Expertise**

- **Patient’s personal background and experience with condition**

- **Evidence based Shared Decision Making process**
To address these problems, we created an application to help patients navigate their patient journey.

**Navigating the Patient Journey**

**PROMs* Q-Guide** (Procedure Decision Support)

- **PROs Survey(s)**
- **Assess Appropriateness Criteria**
- **Shared Decision Making**
- **Personalized Risk (Consent Form)**

**PROMs**

- **Short-term Outcome Measures**
- **Long-term Outcome Measures**

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*Patient reported outcome measures
Patient journey criteria in action

Guidelines and best practices
Evidence based medicine using recent guidelines, publications, and consensus

Procedural Risks and Benefits
Quantitative patient-specific risk models for peri-operative and post-operative risks

Summary Assessment
Appropriateness scores
Specific risks and benefits
Patient preference

Outputs
- Personalized patient consent form
- Documentation in Electronic Health Record
- Prior authorization form(s)
- Shared decision making materials
Current state:
- Assessing pre-procedural appropriateness is variable and infrequently documented.

Patient concerns:
- Is this procedure right for me?
- Are there alternative treatments?

Solution:

Appropriateness criteria

Current state:
- Assessing pre-procedural appropriateness is variable and infrequently documented.

Patient concerns:
- Is this procedure right for me?
- Are there alternative treatments?
Lumbar-Spine Procedure – Assessment Page

Appropriateness Scores:
- Lumbar Discectomy: Rarely Appropriate
- Lumbar Laminectomy: May Be Appropriate
- Lumbar Discectomy + Fusion: Rarely Appropriate
- Lumbar Laminectomy + Fusion: Appropriate
- Lumbar Fusion: Appropriate
- Non-operative Management: Appropriate

Risk Scores:
- Revised Cardiac Risk Index: 2.3%

Patient Reported Outcomes Measures:
- Oswestry Disability Index (ODI) Score

Patient Preferences:
- Patient does not prefer confirmed procedure over other choices (1)
- Patient strongly prefers confirmed procedure over other choices (5)
- N/A (5)

Lumbar Fusion was confirmed by etc19 on 05-15-2015 at 12:19:44 PM
Q-Guide Algorithm for Lumbar Spine Surgery: Disc herniation and recurrent herniation, with radiculopathy

Q-Guide brings appropriate-use guidelines to the point-of-care via a user interface that is launched from the patient’s chart.
Users can view their appropriateness rates over time.
Shared decision making

Current state:
- Incorporating communication tools into daily practice has proved challenging.
- Patients don’t often receive information on their personal risks for a procedure

Patient concerns:
- What are the risks and benefits for patients like me?

Solution:

[Diagram showing PROMs PrOE (Procedure Decision Support) flows through Physician Encounter, Possible Need for Procedure, Informed Consent, Schedule OR, Pre-procedure Testing, Procedure, Recovery]

[Charts showing data on outcomes and risk factors]
Our strategy to engage patients in SDM

• **We are developing two parallel strategies:**
  – Display and visualize personalized risks
  – Capture patient preference
Incorporating risk visualization into Shared Decision Making
Incorporating personalized risk information into the consent process

**Factors that suggest benefits of surgery**
- Current obstruction
- Improved activities of daily living
- Improved appearance
- Located on lower abdomen
- Reduced pain at site of hernia

**Factors that suggest risks of surgery**
- Condition that impairs tissue repair
- History of diabetes
- Previous radiation to site
- Very large hernia
Capturing patient preference for surgery

### Factors that suggest benefit of surgery
- Cosmetic concern
- Current obstruction
- Limitation of enjoyed activities

### Factors that suggest risk of surgery
- BMI > 35
- Condition that impairs tissue repair
- History of diabetes
- Previous radiation to site
- Previous wound infection

### Patient Preferences (Surgery)
- **1** Patient does not prefer surgery
- **2**
- **3**
- **4** Patient strongly prefers surgery
- **5**
- **N/A**

### Decision
- Incisional Hernia Repair
  - Confirm Incisional Hernia Repair
- Watchful Waiting
  - Confirm Watchful Waiting

### QPID PrOE
- Maliktest, Three (2817567) 104/M
- Visit Date: 2014-05-06
- Selected Intervention: Incisional Hernia Repair
- Assessment completed.
Converting the Informed Consent From a Perfunctory Process to an Evidence-Based Foundation for Patient Decision Making

Suzanne V. Arnold, Carole Decker, Homaa Ahmad, Olawale Olabiyi, Surya Mundluru, Kimberly J. Reid, Gabriel E. Soto, Sarah Gansert and John A. Spertus

*Circ Cardiovasc Qual Outcomes* 2008;1:21-28;
DOI: 10.1161/CIRCOUTCOMES.108.791863

**Conclusions**—In this preliminary, single-center experience, individualized consent forms with patient-specific risks were associated with improved participation in the consent process, reduced anxiety, and better risk recall. PREDICT is one potential strategy for improving the current practice of obtaining informed consent for percutaneous coronary intervention. (*Circ Cardiovasc Qual Outcomes*. 2008;1:21-28.)
Patient reported outcome measures

Current state:
• Beginning to measure PROs in a standardized way at the point-of-care.

Patient concerns:
• What outcomes really matter to me?
  – Symptoms and functional status
  – Recovery and sustainability of health

Solution:
Navigating the Patient Journey: Progress to date

Partners Q-Guide Assessments
Feb 2013-May 2015

- 5,773 assessments completed
- 12 Specialties supported

Partners PROMs Collection
March 2014-March 2015

- 30,738 surveys collected to date
- 18 Specialty or subspecialties supported

Appropriateness breakdown, by procedure
(Feb 2014- Feb 2015, Hernia and IVC filter: Feb 2015)

*adhering to guidelines; no appropriateness scores
What does the public really know about providers' rates of appropriate procedures?

Study: One-Quarter of Diagnostic Catheterizations for Suspected Coronary Artery Disease are Unnecessary

ALBANY, N.Y. (February 10, 2014) -- One-quarter of patients undergoing diagnostic catheterizations (DC) for suspected coronary artery disease in New York were rated as inappropriate for the procedure primarily because they were relatively healthy, a recent study finds.

In the study published in January’s Circulation: Cardiovascular Interventions, University at Albany School of Public Health and New York State Department of Health researcher Edward Hannan examined New York’s Cardiac Diagnostic Catheterization Database to identify patients undergoing DC for coronary artery disease between 2010 and 2011.

Patients were rated using appropriateness criteria developed by professional societies as appropriate, uncertain, and inappropriate for DC. The relationships between various patient characteristics and the appropriateness ratings were examined, along with the relationships between hospital-level inappropriateness for DC and other hospital-level variables (hospital DC volume and percutaneous coronary intervention inappropriateness).

Of the 8,986 patients who were rated, 35.3 percent were rated as appropriate, 39.8 percent as uncertain, and 24.9 percent as inappropriate for DC. Of the 2,240 patients rated as inappropriate, 56.7 percent were asymptomatic, had no previous stress test, or had low or intermediate coronary artery disease...
How should providers respond? Demonstrating Appropriateness

Appropriateness Scores for Diagnostic Catheterization for Suspected CAD at MGH* vs. NY Cardiac Database**

![Graph showing appropriateness scores for diagnostic catheterization.]

Median hospital-level inappropriateness rate is 28.5%*

ROI: MGH Data collection and reporting ~1 hour, NY ~3 years

*MGH Data reflect the time period 8/2013- 8/2014.
By December 2015, Q-Guide will assess 9 of the 20 most costly procedures

<table>
<thead>
<tr>
<th>Rank</th>
<th>First-listed OR procedure*</th>
<th>Aggregate costs for hospital stays, $ in millions</th>
<th>Percent of aggregate costs for stays with OR procedures, %</th>
<th>Mean cost per hospital stay, $</th>
<th>Number of stays, in thousands</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Spinal fusion</td>
<td>10,867</td>
<td>63</td>
<td>465</td>
<td>10,867</td>
</tr>
<tr>
<td>2</td>
<td>Arthroplasty of knee</td>
<td>8,400</td>
<td>51</td>
<td>711</td>
<td>8,400</td>
</tr>
<tr>
<td>3</td>
<td>Percutaneous coronary angioplasty (PTCA)</td>
<td>7,200</td>
<td>46</td>
<td>517</td>
<td>7,200</td>
</tr>
<tr>
<td>4</td>
<td>Hip replacement, total and partial</td>
<td>6,900</td>
<td>46</td>
<td>517</td>
<td>6,900</td>
</tr>
<tr>
<td>5</td>
<td>Cesarean section</td>
<td>5,900</td>
<td>46</td>
<td>1,269</td>
<td>5,900</td>
</tr>
<tr>
<td>6</td>
<td>Colorectal resection</td>
<td>5,400</td>
<td>33</td>
<td>289</td>
<td>5,400</td>
</tr>
<tr>
<td>7</td>
<td>Coronary artery bypass graft (CABG)</td>
<td>5,400</td>
<td>33</td>
<td>166</td>
<td>5,400</td>
</tr>
<tr>
<td>8</td>
<td>Heart valve procedures</td>
<td>5,400</td>
<td>33</td>
<td>114</td>
<td>5,400</td>
</tr>
<tr>
<td>9</td>
<td>Cholecystectomy and common duct exploration</td>
<td>4,200</td>
<td>26</td>
<td>400</td>
<td>4,200</td>
</tr>
<tr>
<td>10</td>
<td>Treatment, fracture or dislocation of hip and femur</td>
<td>3,800</td>
<td>23</td>
<td>255</td>
<td>3,800</td>
</tr>
<tr>
<td>11</td>
<td>Procedures related to cardiac pacemaker or cardioverter/defibrillator</td>
<td>3,200</td>
<td>20</td>
<td>122</td>
<td>3,200</td>
</tr>
<tr>
<td>12</td>
<td>Hysterectomy, abdominal and vaginal</td>
<td>3,000</td>
<td>20</td>
<td>351</td>
<td>3,000</td>
</tr>
<tr>
<td>13</td>
<td>Debridement of wound, infection or burn</td>
<td>3,000</td>
<td>20</td>
<td>128</td>
<td>3,000</td>
</tr>
<tr>
<td>14</td>
<td>Amputation of lower extremity</td>
<td>2,100</td>
<td>13</td>
<td>121</td>
<td>2,100</td>
</tr>
<tr>
<td>15</td>
<td>Appendectomy</td>
<td>2,000</td>
<td>13</td>
<td>265</td>
<td>2,000</td>
</tr>
<tr>
<td>16</td>
<td>Small bowel resection</td>
<td>1,500</td>
<td>9</td>
<td>70</td>
<td>1,500</td>
</tr>
<tr>
<td>17</td>
<td>Laminectomy, excision intervertebral disc</td>
<td>1,500</td>
<td>9</td>
<td>203</td>
<td>1,500</td>
</tr>
<tr>
<td>18</td>
<td>Treatment, fracture or dislocation of lower extremity (other than hip or femur)</td>
<td>1,200</td>
<td>7</td>
<td>162</td>
<td>1,200</td>
</tr>
<tr>
<td>19</td>
<td>Lobectomy or pneumonectomy</td>
<td>800</td>
<td>5</td>
<td>84</td>
<td>800</td>
</tr>
<tr>
<td>20</td>
<td>Circumcision</td>
<td>200</td>
<td>1</td>
<td>955</td>
<td>200</td>
</tr>
</tbody>
</table>

Nationally, these 9 procedures account for $64 billion, or 63% of the total costs of the 20 most costly OR procedures in the US:

- Spine fusion
- Spine laminectomy
- Knee arthroplasty
- Hip replacement
- PCI
- CABG
- Heart valve repair/replacement
- AICD implantation
- Hysterectomy
## Q-Guide procedures: across the system

<table>
<thead>
<tr>
<th>Department/Division</th>
<th>Procedure</th>
<th>MGH</th>
<th>BWH</th>
<th>NWH**</th>
<th>Included in AHRQ Top 20 List</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vascular</td>
<td>Peripheral Artery Disease: Angioplasty/Stent/Med Rx</td>
<td>FY2015</td>
<td></td>
<td></td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Carotid Artery Disease: CAS/CEA/Med Rx</td>
<td></td>
<td>Live</td>
<td></td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Vena Cava Filter Placement</td>
<td></td>
<td>Live</td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>Cardiology</td>
<td>Diagnostic Catheterization</td>
<td>Live</td>
<td></td>
<td>FY2015*</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>PCI</td>
<td>FY2015</td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>AICD/PM Implantation</td>
<td></td>
<td>Live</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Cardiac Surgery</td>
<td>CABG</td>
<td></td>
<td>Live</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Valve procedures</td>
<td></td>
<td>Live</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Spine</td>
<td>Cervical procedures</td>
<td>FY2015</td>
<td>FY2015</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Lumbar procedures: Fusion, Laminectomy, Discectomy</td>
<td>Live</td>
<td>Live</td>
<td>FY2015*</td>
<td>Yes</td>
</tr>
<tr>
<td>Orthopaedics</td>
<td>THA</td>
<td>FY2015</td>
<td>FY2015*</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>TKA</td>
<td>FY2015</td>
<td>FY2015*</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>General Surgery</td>
<td>Prophylactic Mastectomy</td>
<td>FY2015</td>
<td></td>
<td></td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Incisional Hernia Repair</td>
<td></td>
<td>Live</td>
<td></td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Weight Loss: Gastric Bypass, Sleeve, Lap-Band</td>
<td></td>
<td>Live</td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>Urology</td>
<td>Prostate Cancer: Active Surveillance and treatment</td>
<td>FY2015</td>
<td></td>
<td></td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Prostate Biopsy</td>
<td></td>
<td>Live</td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>Gynecology</td>
<td>Hysterectomy</td>
<td>FY2015</td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Dermatology</td>
<td>Mohs Procedures</td>
<td>FY2015</td>
<td></td>
<td></td>
<td>No</td>
</tr>
</tbody>
</table>

*tentatively planned  **other pilots under consideration
Key elements of the program

- Consensus process
- Leveraging IT infrastructure
- The importance of champions
- Redesigning prior authorization
Consensus process: i.e. lumbar spine

1. Multidisciplinary consensus on indications
2. Create decision support logic

I. Identify Clinical and Administrative Champions
   • To provide content, steer the clinical dialogue, and champion Q-Guide

II. Identify procedure and indications
   • Includes clinical and administrative leadership
   • Use published guidelines as a starting point
   • Criteria include volume, cost, potential for overuse and opportunity for shared decision making

III. Created Expert Advisory Panel to provide feedback
    • Vetting with interdisciplinary experts

IV. Consensus on clinical guidelines and scoring criteria
    • Requires subject matter expert input

V. Beta testing
    • Providers test the application and provide feedback
Consensus on clinical content and decision support i.e. Lumbar spine

1. Multidisciplinary consensus on indications

2. Create decision support logic

Once we agree on the indications, we use a modified RAND approach to gain consensus based on specific clinical scenarios

| Green: Consensus on guidelines |
| Yellow: Inconsistent data led to treatment equipoise |
| Red: Insufficient outcomes and evidence |
Leveraging IT infrastructure

- Natural language processing (NLP) technology to mine the EHR to pre-populate fields in the Q-Guide UI. Minimize clicks for the user.

- Integration

<table>
<thead>
<tr>
<th>System</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scheduling systems</td>
<td>Users are prompted to complete Q-Guide when ordering a diagnostic procedure or scheduling a surgical procedure</td>
</tr>
<tr>
<td>New EHR system</td>
<td>Q-Guide can access information from across the network</td>
</tr>
<tr>
<td>Patient reported outcome measures</td>
<td>Results can be brought into the Q-Guide application and can inform clinical decision-making</td>
</tr>
<tr>
<td>Document filing system</td>
<td>Q-Guide results can be saved in a note format that providers across the network can access</td>
</tr>
</tbody>
</table>
Champions can help address barriers to adoption

<table>
<thead>
<tr>
<th>Incentives</th>
<th>Champions can help to communicate the value proposition and align incentives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investment</td>
<td>Champions can align central and local investment in IT applications</td>
</tr>
<tr>
<td>Workflow</td>
<td>Seek solutions to physician adoption in busy workflows</td>
</tr>
<tr>
<td>Consensus</td>
<td>Requires physicians to agree to clinical guidelines where often there are none. Champions can provide leadership and direction.</td>
</tr>
<tr>
<td>Review/Measurement</td>
<td>Opportunity to measure individual provider performance and RSO performance, and study variation</td>
</tr>
<tr>
<td>Standardization</td>
<td>A high degree of variation exists and finding agreed upon standards can be challenging</td>
</tr>
</tbody>
</table>
Prior Auth is a burden on our physicians: Results of the 2014 MGPO Survey

“...one theme was clear: a strong majority of physicians report that administrative requirements negatively affect their ability to focus and deliver high quality care.”

“The most burdensome tasks included prior authorizations, ambulatory clinical documentation, and medication reconciliation.”

Source: The Fruit Street Physician, September 2014; 23(8) http://mgpo.partners.org/
Collaboration with Payers

• Partners HealthCare collaborates with payers to address administrative burden, promote appropriateness, and reduce costs.

• Payers accept Q-Guide as a replacement for the standard prior authorization (PA) process for lumbar spine procedures.

• Pilot aims to ‘do the right thing’ for patients and reduce administrative burden associated with PA for providers.

• Our experience has shown thus far that it is possible to collaborate with payers to redesign the prior auth process.

Payers are conducting evaluations to assure themselves that Total Medical Expense doesn’t increase.
Consensus process: i.e. lumbar spine

I. Identify Clinical and Administrative Champions
   • To provide content, steer the clinical dialogue, and champion Q-Guide

II. Identify procedure and indications
   • Includes clinical and administrative leadership
   • Use published guidelines as a starting point
   • Criteria include volume, cost, potential for overuse and opportunity for shared decision making

III. Created Expert Advisory Panel to provide feedback
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IV. Consensus on clinical guidelines and scoring criteria
   • Requires subject matter expert input

V. Beta testing
   • Providers test the application and provide feedback

Collaboration with payer every step of the process
Lumbar spine provider-payer collaboration: Progress to date

- **Pilot dates:** Sept 8, 2014 – May 31, 2015

- **Active pilot sites:**
  - MGH Ortho/Spine
  - MGH Neurosurgery
  - BWH Ortho/Spine
  - BWH Neurosurgery

- **Q-Guide assessments completed:**
  - 142 total (64 at MGH; 78 at BWH)
  - 92% appropriate

- **Patients receiving decision aids:** 77%
Q-Guide case review process (i.e. Lumbar Spine)

**Identify**
'Maybe' & 'Rarely' appropriate cases
- Q-Guide system returns a 'red' or 'yellow'
- Provider provides an exception

**Monitor**
- Ongoing monitoring of green, yellow, and red cases

**Review**
- PHS peer-review of case and rationale for proceeding

**Revise**
- Based on consensus, revise guidelines when appropriate

**Document**
- Document case review in EHR

**Proceed**
- Proceed with the case

‘Maybe’ and ‘Rarely’ appropriate lumbar spine cases follow this process
Current prior authorization process

<table>
<thead>
<tr>
<th>Clinical Office</th>
<th>Patient visits surgeon and lumbar laminectomy is indicated</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Surgeon schedules procedure</td>
</tr>
<tr>
<td></td>
<td>Admin knows procedure requires PA?</td>
</tr>
<tr>
<td></td>
<td>Admit calls clinic to work through PA form</td>
</tr>
<tr>
<td></td>
<td>Admin faxes form to admitting</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Patient undergoes procedure</td>
</tr>
<tr>
<td>Admitting</td>
<td>Admitting checks for form</td>
</tr>
<tr>
<td></td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Admitting checks for form</td>
</tr>
<tr>
<td></td>
<td>Decision submitted to Admitting</td>
</tr>
<tr>
<td></td>
<td>Denied</td>
</tr>
<tr>
<td></td>
<td>Admitting enters auth # in PATCOM</td>
</tr>
<tr>
<td></td>
<td>Manually appeal claim</td>
</tr>
<tr>
<td>Payer</td>
<td>Admitting submits PA</td>
</tr>
<tr>
<td></td>
<td>PA reviewed by third party</td>
</tr>
</tbody>
</table>
Creating a more efficient prior authorization process

<table>
<thead>
<tr>
<th>Clinical Office</th>
<th>Admitting</th>
<th>Payer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient eligibility confirmed</td>
<td>Admin staff print Q-Guide Authorization form* and fill in ICD and CPT codes.</td>
<td>Potential savings:</td>
</tr>
<tr>
<td>Q-Guide assessment completed. Consent form generated.</td>
<td></td>
<td>• Current vs new process:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>o Clinical Office: 4-5 steps vs 3 steps</td>
</tr>
<tr>
<td></td>
<td></td>
<td>o Admitting: 4 steps vs 3 steps</td>
</tr>
<tr>
<td></td>
<td></td>
<td>o Payer: 2 steps vs 1 step</td>
</tr>
<tr>
<td></td>
<td></td>
<td>uploaded to LMR/sent to Admitting</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Admitting documents auth # in system</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Confirmation received within 1-3 days</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prior authorization granted upon receipt of Q-Guide form</td>
</tr>
</tbody>
</table>

**Potential savings:**
- Current vs new process:
  - Clinical Office: 4-5 steps vs 3 steps
  - Admitting: 4 steps vs 3 steps
  - Payer: 2 steps vs 1 step

**Legend:**
- Physician
- Admin staff
User feedback on new prior authorization process

“My office staff, me, and my PA all feel that the process has been greatly improved with Q-Guide.” Physician

“...it’s going well and it is easier than the Smartsheet process.” Admitting department

“the surgeries that we’ve scheduled are getting approved without a problem...” Frontline administrative staff in clinic

“The authorization process is working smoothly.” Payer operations

“The pilot process made it clear that our goals in achieving cost effective quality health care are aligned and that through working together we can understand each other’s “pain points” as we develop shared solutions.” Payer leadership
## The Optimal Patient Journey: Challenges and Opportunities

<table>
<thead>
<tr>
<th>Challenge</th>
<th>Opportunity</th>
</tr>
</thead>
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<td>Integrating into busy provider workflow</td>
<td>• Reduce Q-Guide ‘hands-on-keyboard’ to less than 90 seconds</td>
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| Technical integration (i.e. Epic)                             | • Partial Epic integration approved  
• Full Q-Guide integration into Epic workflow in planning stages |
| Continuously updating guidelines                              | • Provider-driven best practices are updated more frequently than society guidelines  
• Specialists jointly decide on controversial clinical decisions |
| Collaboration with payers to simplify administrative burden (prior authorization) moves slowly | • Working to change payers’ viewpoint that utilization management is their domain |
Why this matters in the context of shared financial risk

- Now that PHS accepts financial risk for patients, we own the problem of overuse.
- Partners currently covers over 500,000 lives in an accountable care contract.
- Q-Guide and other population health management strategies — including patient-centered medical homes and high risk care management — are part of our Internal Performance Framework.
Emerging lessons from the front line:

- Payer and providers can successfully collaborate to reduce administrative burden
- Engaging your key stakeholders, including clinical and administrative leadership, is critical to success
- Communicating the appropriateness value proposition to providers is challenging if not participating in an ACO or shared savings plan
- Documenting clinical decision making at the point of care can potentially mitigate unnecessary surgeries
- Standardized presentation of surgical and non-surgical treatment alternatives promotes shared decision making and engages patients
- Requires significant capital and IT infrastructure (including data and analytics)
- Requires management expertise
Physician testimony

“Imagine the impact on patients when I have them watch the computer screen and walk through their current clinical situation, their individual risks of various treatment options (medical treatment, surgery, and catheter-based therapy), receive a ‘score’, and then participate actively in the decision? It is incredible to watch how much more involved they are in the decision.”

-Dr. Michael R. Jaff
Paul and Phyllis Fireman Chair in Vascular Medicine
Medical Director, Vascular Center, Massachusetts General Hospital
Professor of Medicine, Harvard Medical School
Appendix
Challenge #1: Integrating with high-volume practices

Our goal is for providers to be able to complete Q-Guide assessments in two minutes or less.
Challenge #2: Continuously updating guidelines and risk models

Should be green

Can we keep up with specialty society guideline revisions?

Recurrent Disc Herniation

The previous Lumbar Fusion Guidelines concluded that reoperative discectomy is recommended as a treatment option in patients with recurrent disc herniations and radiculopathy. For a first-time recurrence, this recommendation continues to be supported by more recent publications. Fu et al., in a retrospective Level III review, investigated the outcome in 41 cases of recurrent lumbar...