Approach to Physician and Workforce Engagement as Part of ACO-PCMH Transformation

NAPH Webinar
Soma Stout, MD, MS
VP Patient Centered Medical Home Development
Cambridge Health Alliance

Cambridge Health Alliance

A COMMUNITY OF CARING

- An academic public health safety net system outside of Boston – only public health system in MA
- 12 medium-sized community health centers, 3 school-based clinics, 2 hospitals, specialty clinics
- Largely public payer mix – 82%, almost all Medicaid
- >50% patients speak language other than English
- 650,000 outpatient visits/year
- 175,000 primary care visits for 92,000 patients
- Academic and public health mission – poor funding
- Fully unionized staff
- Extremely vulnerable to shifts in public funding

A crisis and an opportunity: Vision 2015

- Had to ask ourselves "Why ***should*** we be around in the Year 2015?"
- Wide engagement of stakeholders from frontline medical staff to senior leadership.
- Examined data about where the organization is, and what the future will look like in 2015.
- Asked frontline staff: What would make you proud to be part of the CHA of 2015? What do we need to get there?

CHA Vision 2015

- Vision 2015: *"The delivery system will be fashioned as a medical home that is highly effective in coordinating care for the whole patient, functioning as a 'practice without walls.'"*
- Required fundamental commitment from CEO and senior leadership:
  - to change our business model to that of an accountable care organization over a 5 year period
  - to change our clinical model to that of a patient-centered medical home neighborhood across primary care, specialties, inpatient, etc

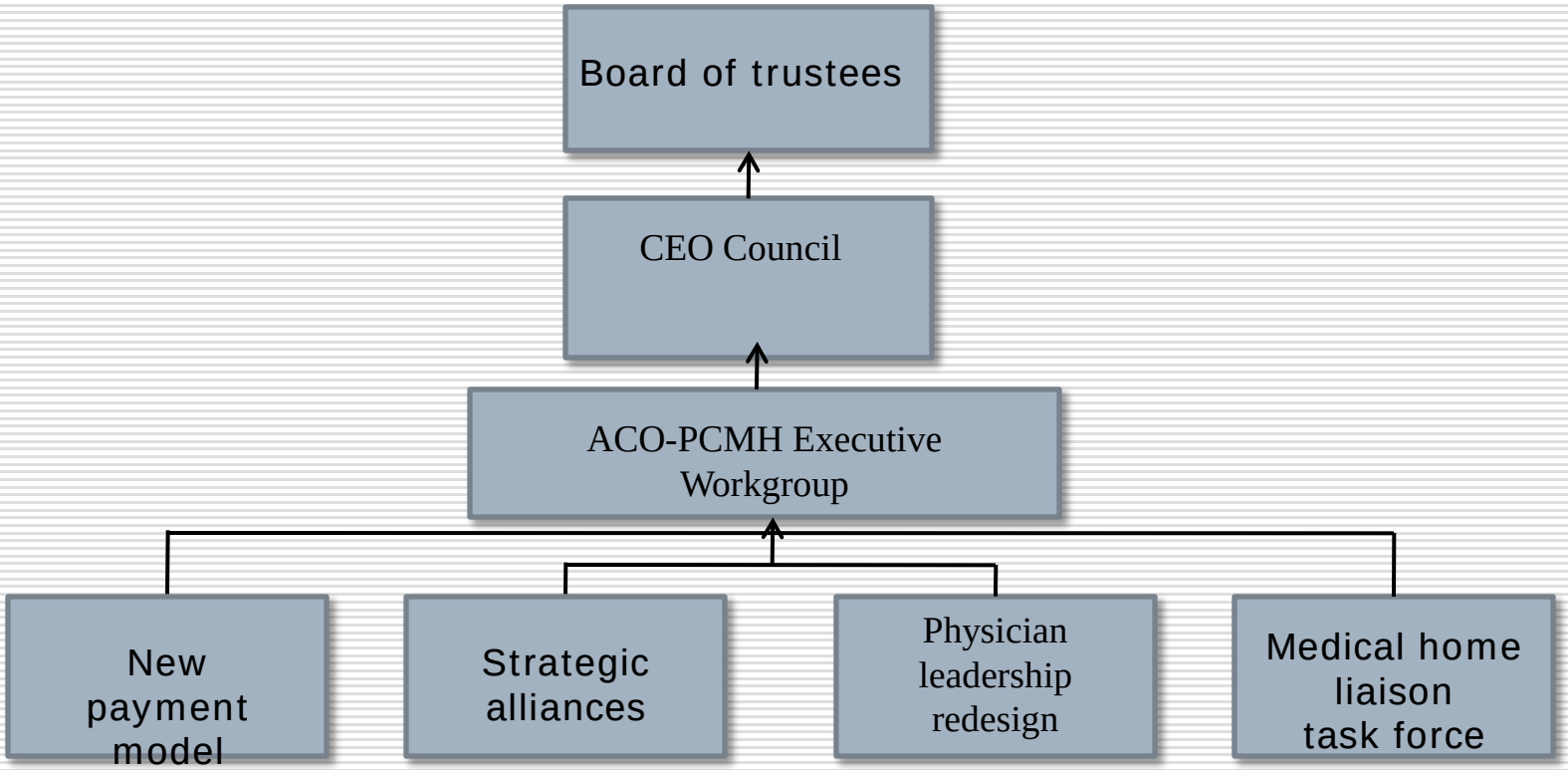
Lesson #1:

This requires alignment and coordination across every level of the organization. Needed an engagement strategy for every level.

Going from Vision to Reality: Creating a guiding coalition

- Formation of ACO-PCMH Steering Committee – brought together the delivery system, senior leadership, clinical leadership, healthplan leadership
  - Development of shared goals, values, language, and vision

An organizational approach



ACO-PCMH Executive Workgroup

- Objectives: Engage senior leadership team to:
  - Develop strategic objectives
  - Oversee all strategy components
  - Direct various project efforts
  - Ensure consistency and focus
  - Resolve interdisciplinary issues
  - Regularly update CEO and board
  - Educate and engage CHA staff

Lesson 2:

You need to deeply engage the physician community

New provider leadership model

- Matrixed organizations need to provide a common point for escalation of decisions when necessary
- Elimination of silos between medical, nursing and administrative leadership
- Shared goals, agendas, accountability
- Single point of accountability

New provider leadership model

- New CMO position created, reports to the CEO
- Provides senior medical leadership for the operation and development of the health system
- The CMO works in partnership with the EVP/COO and together they:
  - oversee delivery system operations
  - ensure appropriate integration and resource allocation to achieve system wide quality, financial and academic goals.

Physician Leadership and Alignment

- Education
- Leadership
- Compensation changes
- Guideline development

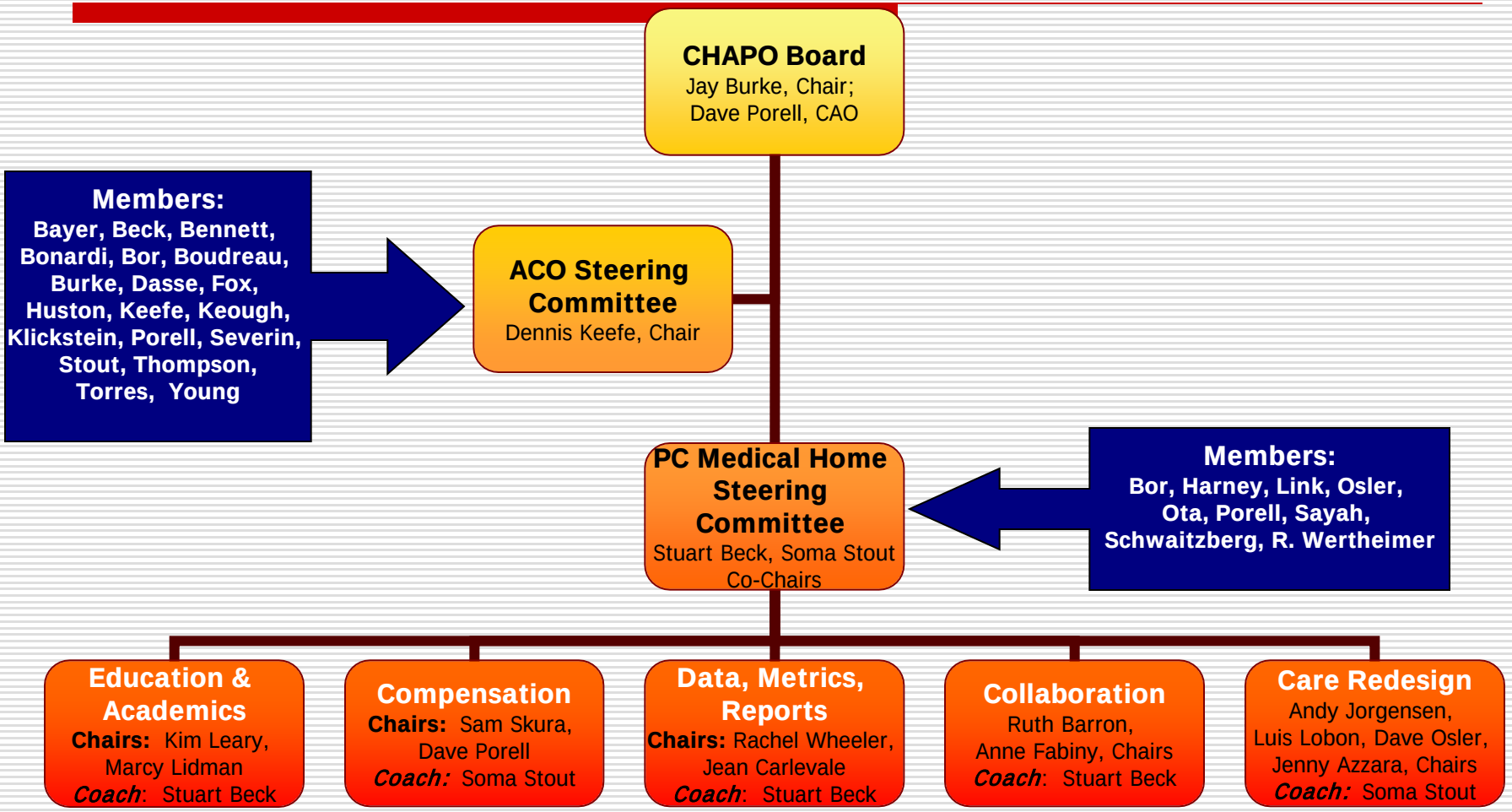
Lesson #3:

Because this requires deep cultural transformation in the way we provide care, it cannot be implemented from the top down as a project. Cultural transformation requires deep engagement of people at the frontline in the vision and its implementation.

Going from Vision to Reality: Creating a group of champions

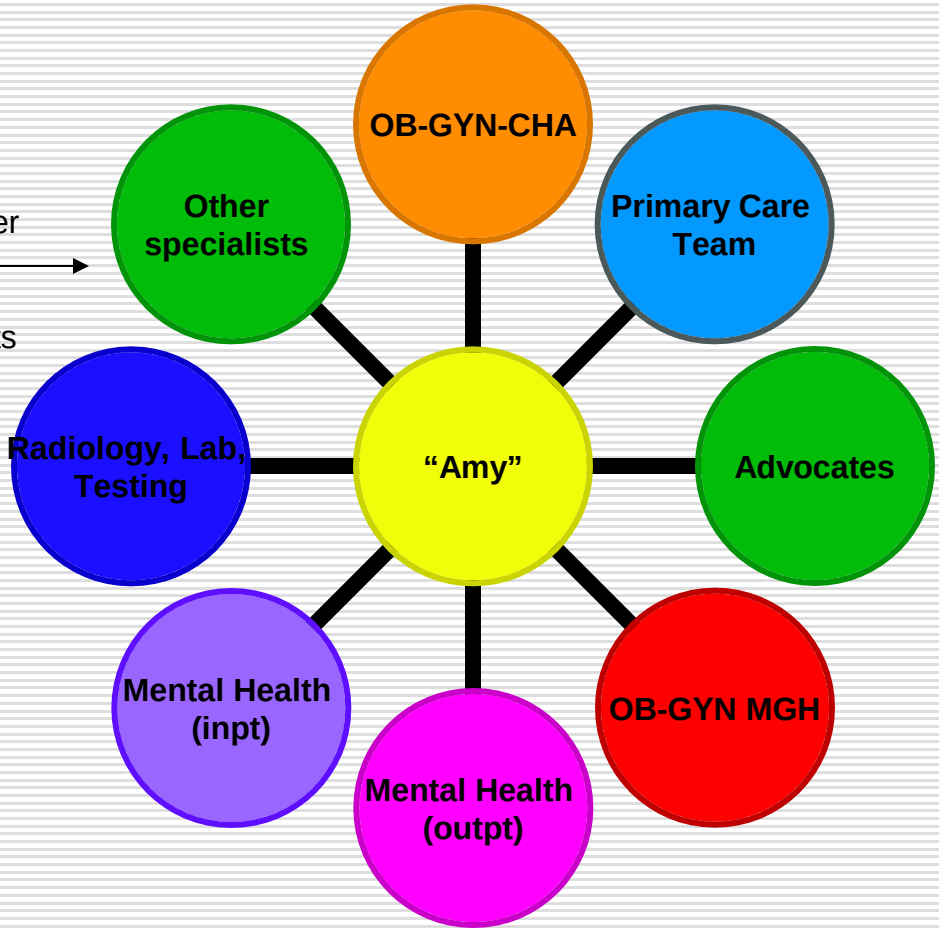
- CHAPO Patient-Centered Medical Home Taskforce
  - Engagement process to recommend what we would need to change to implement the vision
  - Brought together 100 frontline and senior leaders across specialties, medical staff, nursing, administration in 5 workgroups: Care Redesign, Compensation, Education and Academics, Collaboration, and Data, Metrics, Reports
  - Steering Committee made up of senior clinical and administrative leaders

PCMH Taskforce Organizational Structure



Patient-Centered Care Redesign - “Amy”

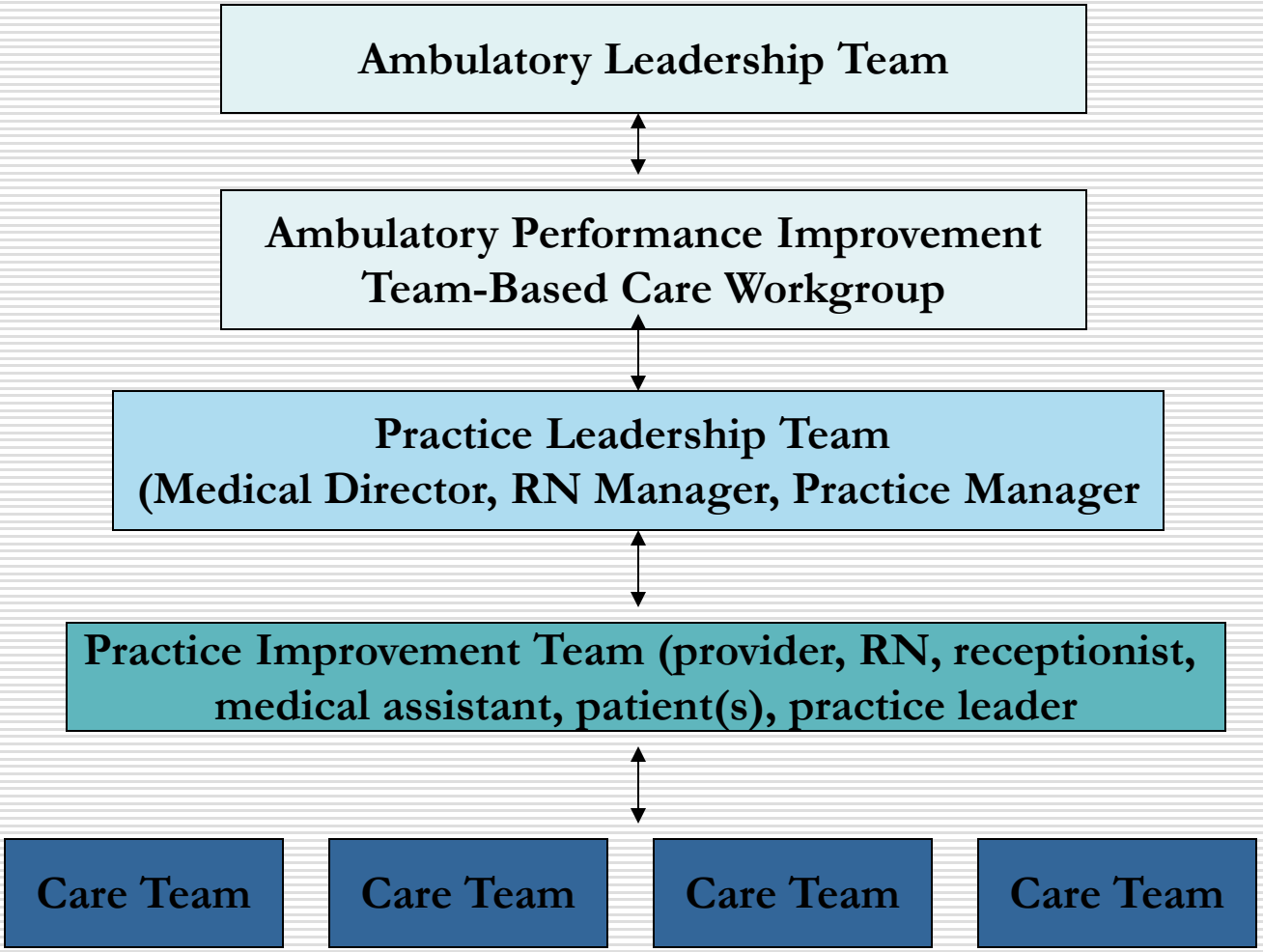
- Diabetes
- Weight Center
- Pulmonary
- Nutrition
- Other patients

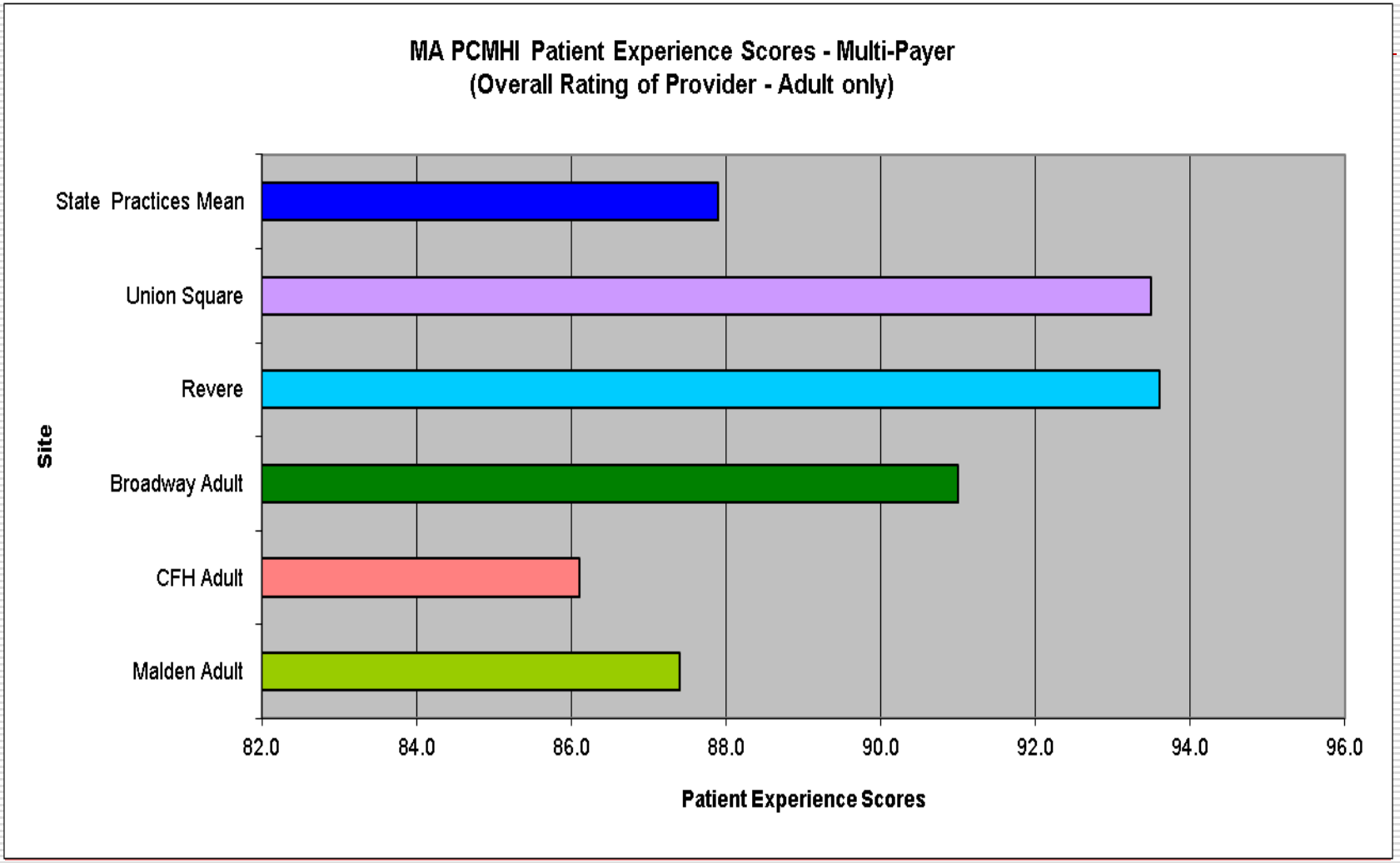


Engaging and inspiring champions

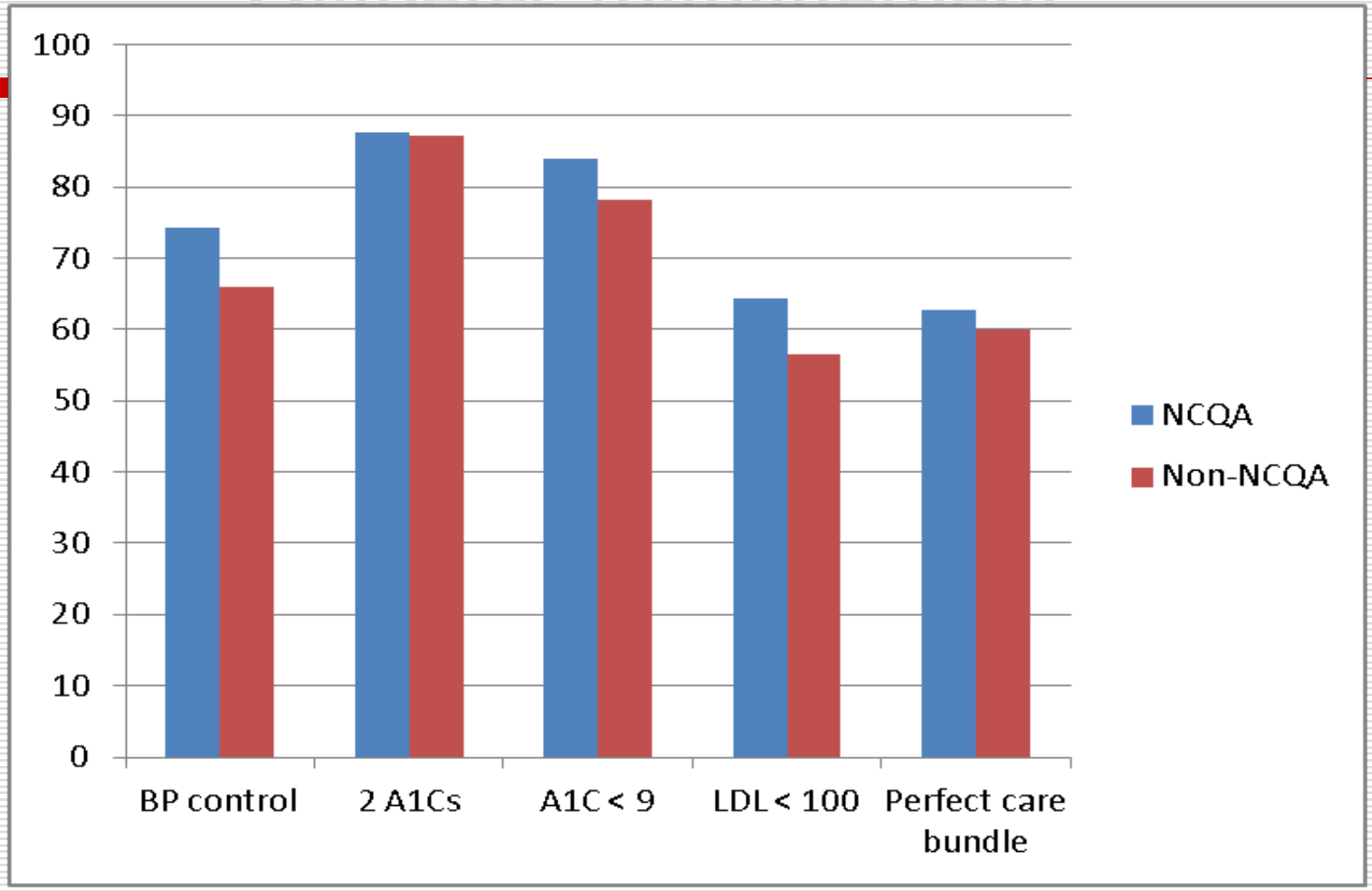
- Created a learning community
  - CHA Leadership Academy
  - Care team training days
- Invited the learning community to help design the transformation
- Learning collaboratives → peer to peer learning and spread
- System of top-down, bottom-up and peer to peer learning
- Care teams as DNA element

Team-Based Improvement Structure



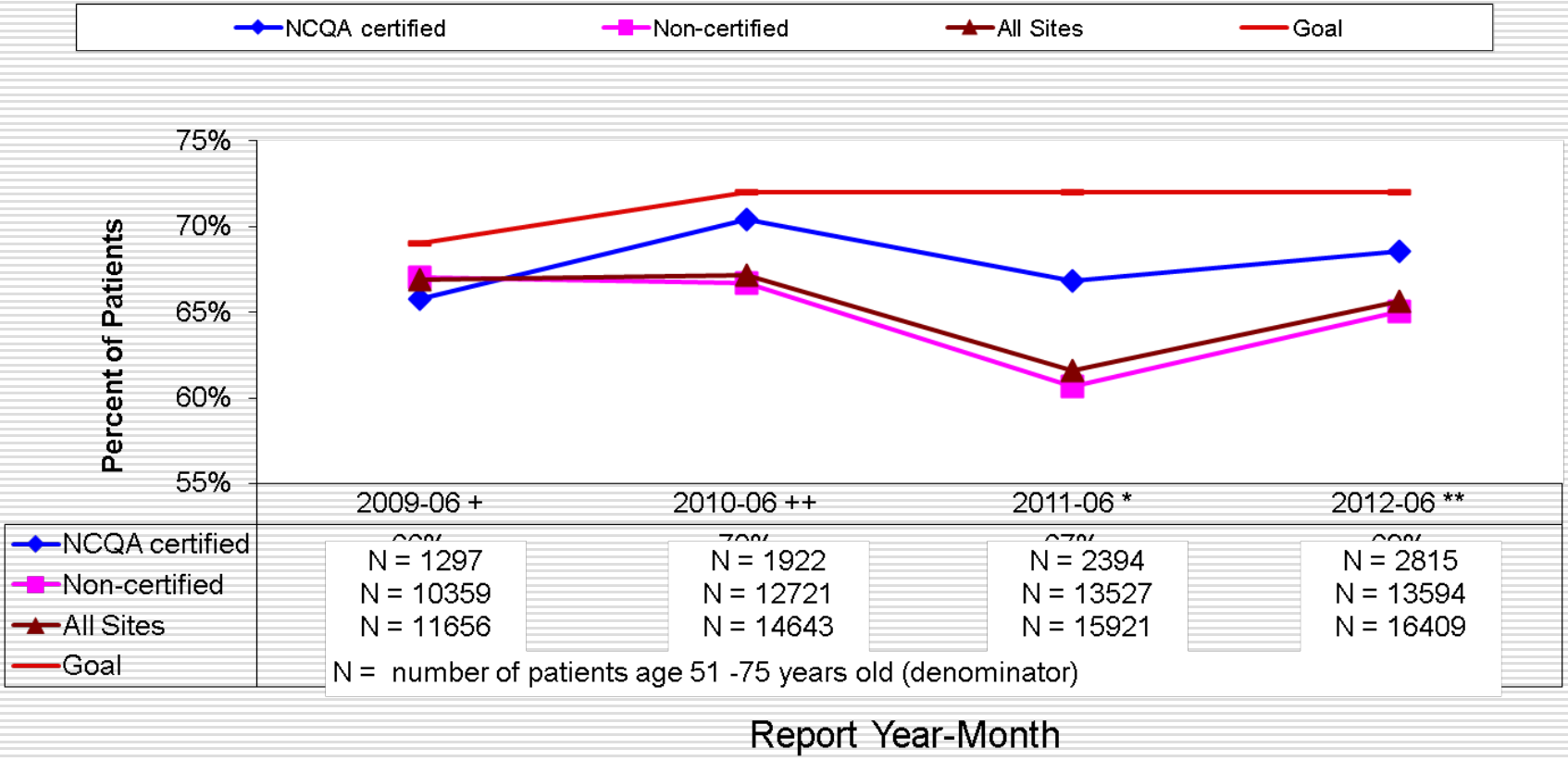

MA PCMHI Patient Experience Scores - Multi-Payer
(Overall Rating of Provider - Adult only)
State Practices Mean
Union Square
Revere
Broadway Adult
CFH Adult
Malden Adult
Site
82.0
84.0
86.0
88.0
90.0
92.0
94.0
96.0
Patient Experience Scores

Diabetes management



Commonwealth Fund evaluation. NCQA sites = Union Square and Revere

Percent of Patients Age 51-75 Screened for Colorectal Cancer



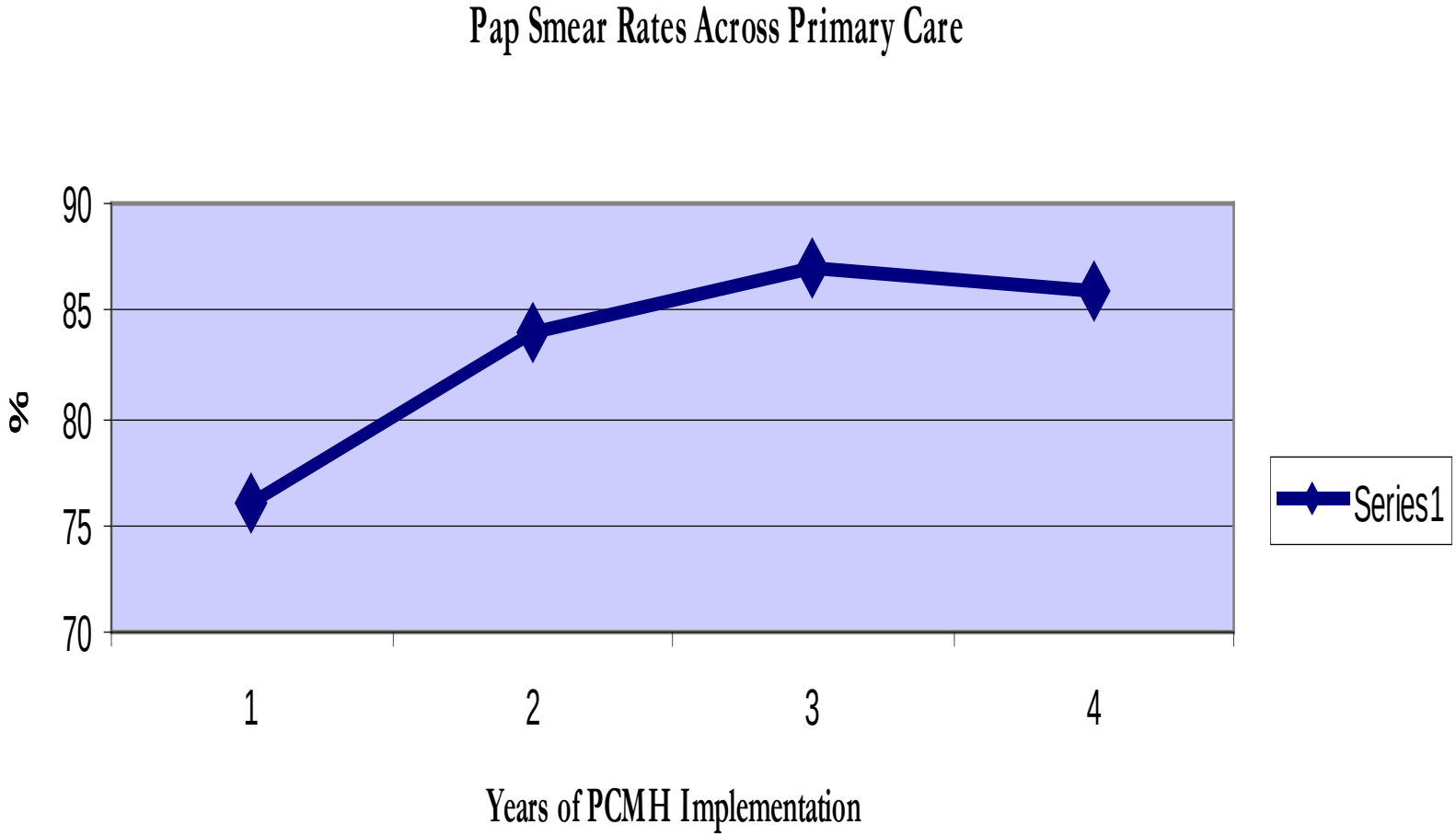
+ Ambulatory Quality Goals for 2009
http://staffnet/Reports/Clinical/Ambulatory/AmbulatoryQualityGoals200906.pdf

++ Ambulatory Quality Goals for 2010
http://staffnet/Reports/Clinical/Ambulatory/AmbulatoryQualityGoals201006.pdf

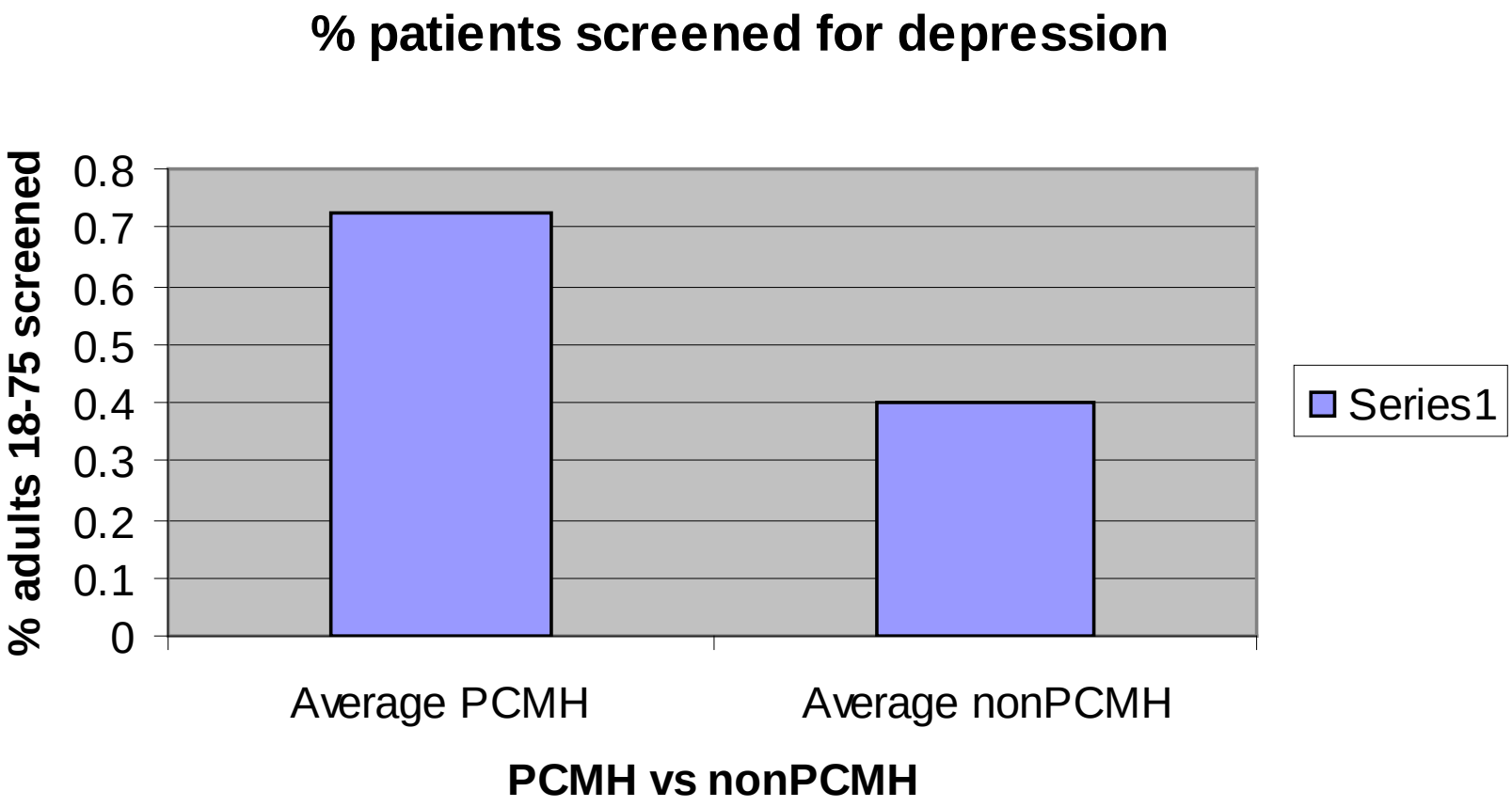
* Ambulatory Quality Goals for 2011
http://staffnet/Reports/Clinical/Ambulatory/AmbulatoryQualityGoals201106.pdf

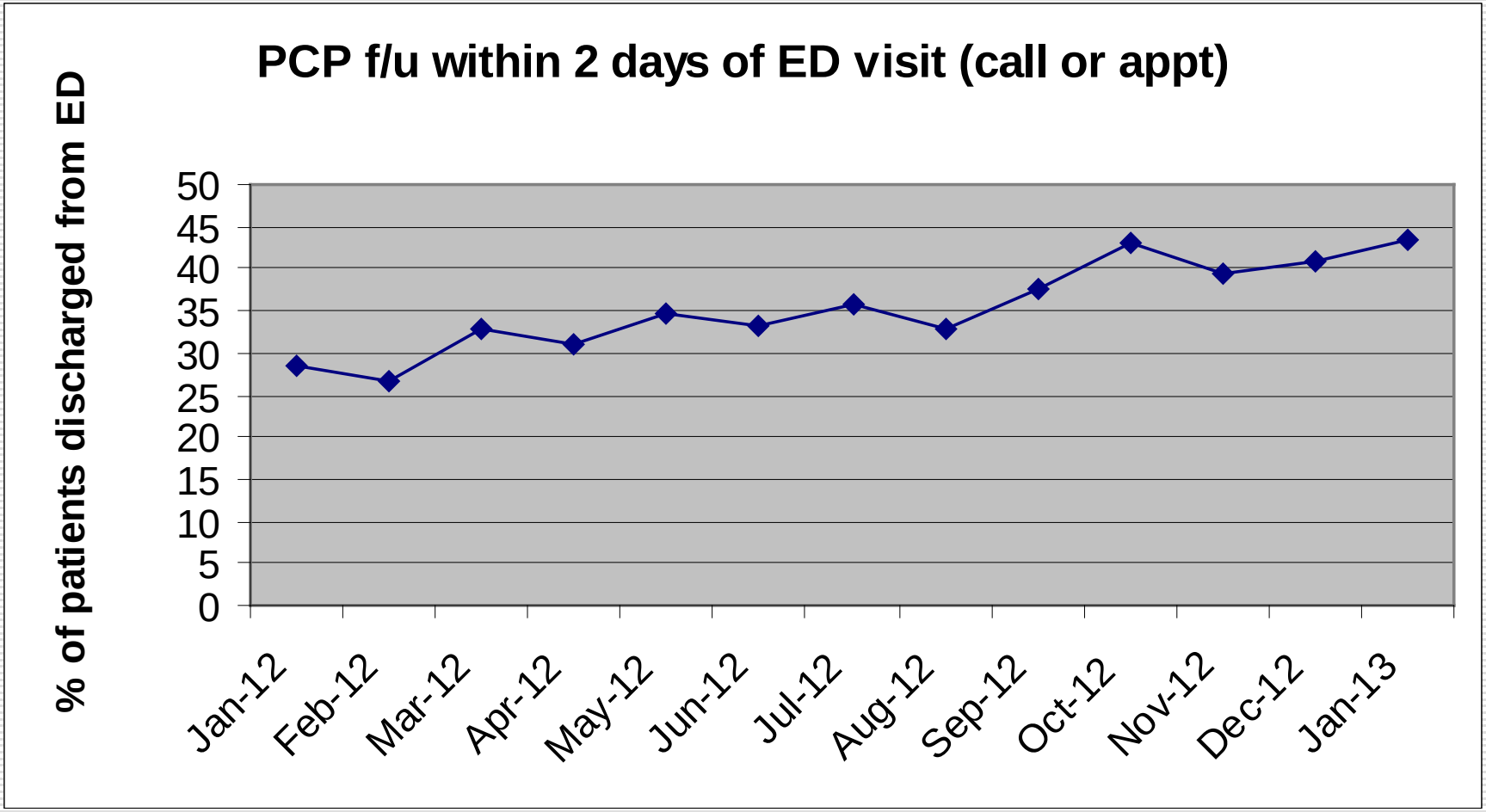
** Ambulatory Quality Goals for 2012
http://staffnet/Reports/Clinical/Ambulatory/AmbulatoryQualityGoals201206.pdf

Improved preventative screening > national 90%ile

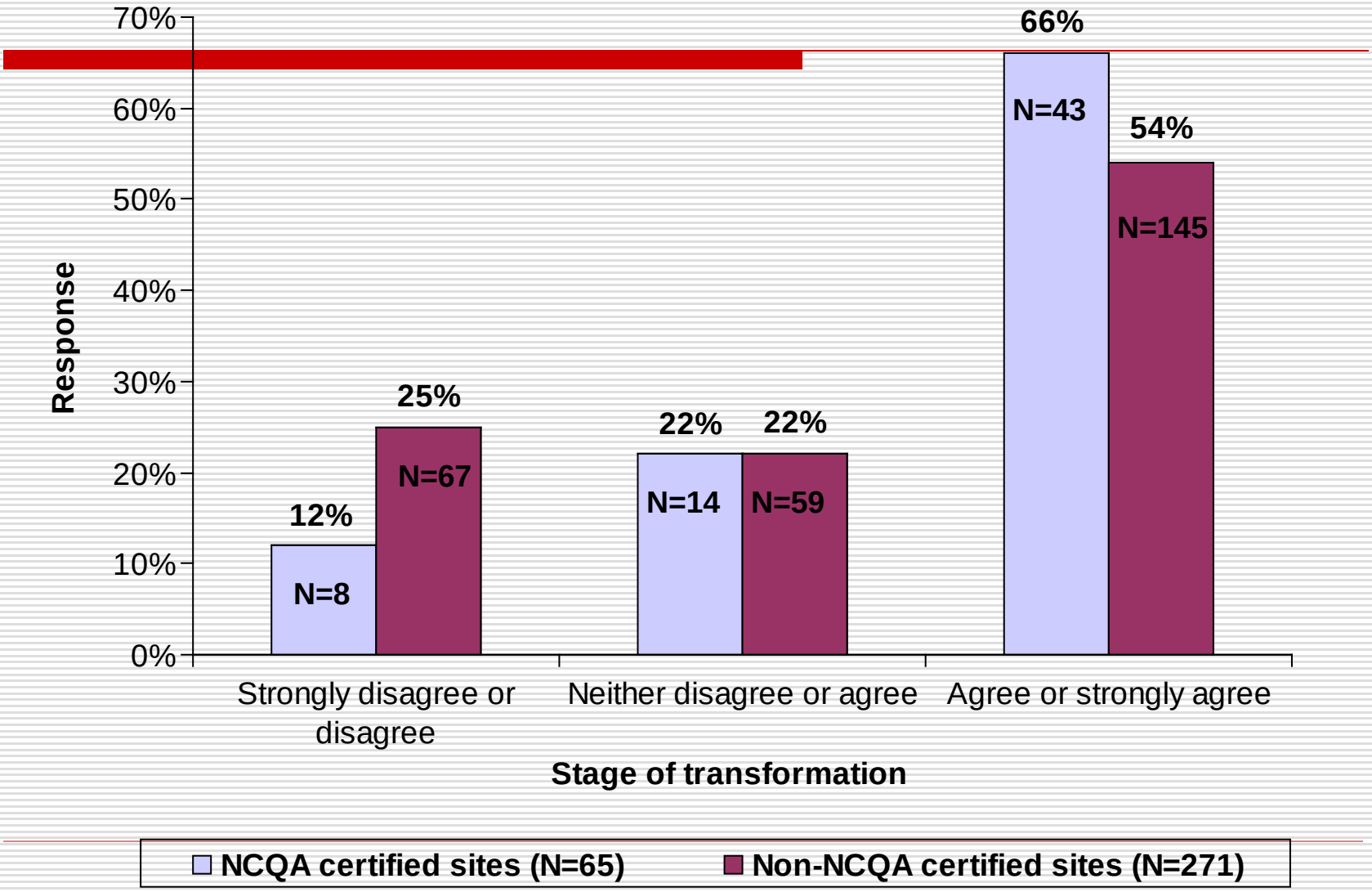


Patients screened for depression

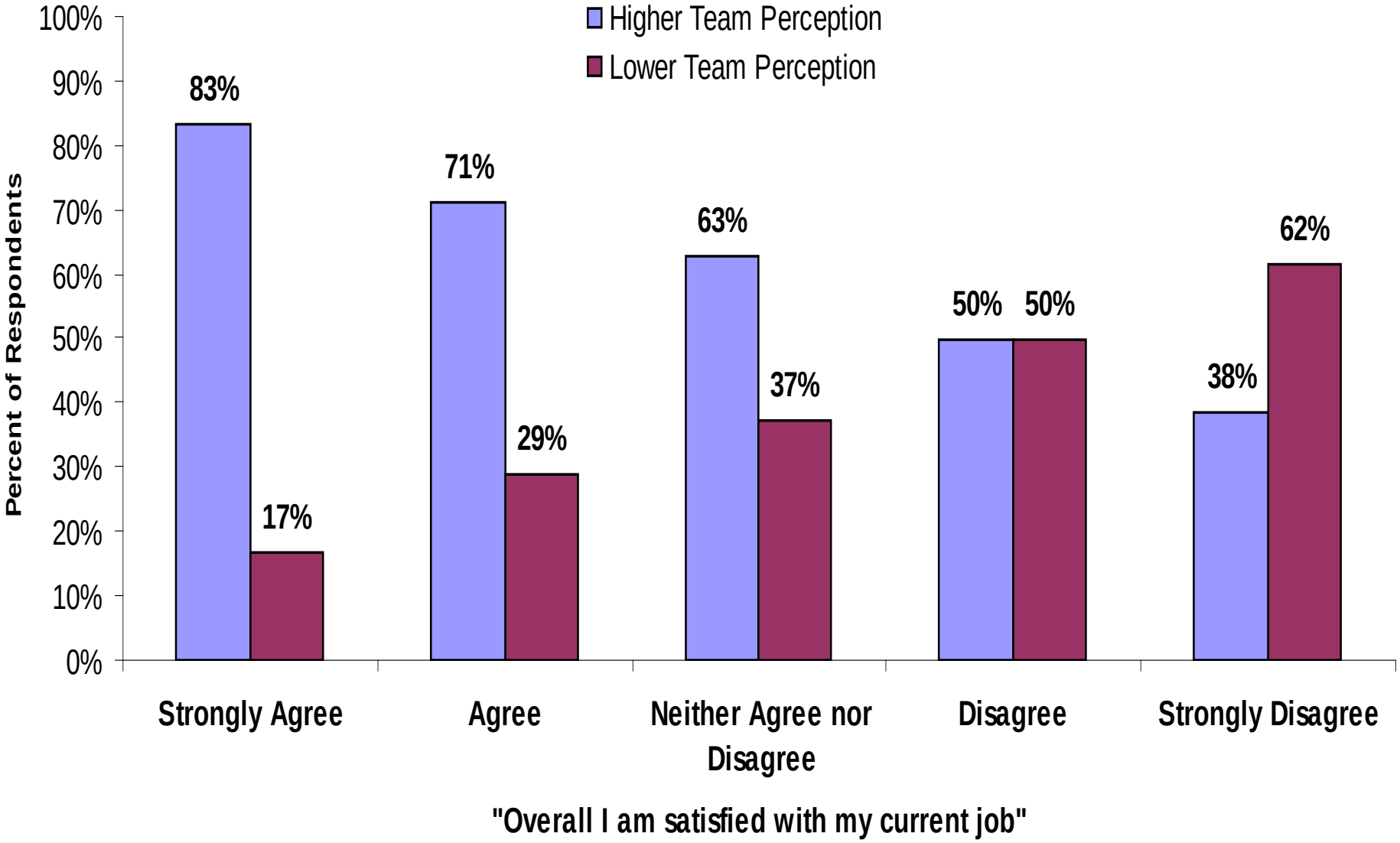



PCP f/u within 2 days of ED visit (call or appt)
% of patients discharged from ED
50
45
40
35
30
25
20
15
10
5
0
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13

CHA PCMH Workforce Survey
Practice operates as a real team (Q11a)



Perception of Teamness by Overall Job Satisfaction



Between Groups P<0.01

PHYSICIAN ALIGNMENT WITH QUALITY IMPROVEMENT, EFFICIENCY, AND PATIENT SATISFACTION

Timothy H. Dellit, MD
Associate Medical Director
Patty Calver, RN BSN
Director of Quality Improvement
Harborview Medical Center

PATIENTS ARE FIRST PILLARS

Harborview Access to Excellence Measures

Last Updated: 4/30/2013

Measure of Performance	Value	Target	Date
Service Oriented and Timely: Service Driven to permit timely access to care.			
Increase Patient Appts to Specialty Clinics Within 14 Days of Referral		10%	Mar 2013
O.R First Starts (within 5 mins)		80%	Mar 2013
ED % Left Without Being Seen		5%	Mar 2013
Fiscally Responsible, Efficient, Equitable Care: Maximize value for all patients,control expenses.			
Monthly (Tot Inc / Tot Oper Rev) - (Budg Tot Inc / Budg Tot Oper Rev)		0%	Mar 2013
FYTD Mean LOS (All Units) (Actual vs Budget) % Variance		0%	Mar 2013
Concurrence with Transfer Criteria		90%	Nov-12
Mental health Integration (Contacts)		50%	Mar 2013
Safe and Effective: Free from harm caused by medical interventions, evidence-based effective care.			
Nosocomial MRSA Rate		0.86	Mar 2013
Central Line-Associated Bloodstream Infections Rate		1.21	Mar 2013
Hand Hygiene Compliance - IP		91%	Apr 2013
AHRQ Patient Safety Indicators (events per 1000 eligible patients)		2.82	Jan-Mar 2013
Mortality: Observed to Expected Ratio		0.61	Feb 2013
Core Measures Aggregate Score		95%	Mar 2013
30 Day All Cause Readmission Composite - AMI, HF, PNA		18%	Jan 2013
Ambulatory Diabetic LDL Rate		80%	Mar 2013
Ambulatory Cancer Screening Rate		68%	Mar 2013
Ambulatory Pneumococcal Vaccine - Age 65+		78%	Mar 2013
Patient-Centered and Employer of Choice: Positive patient/ family ex mployee satisfaction.			
IP Patient Experience (% 9-10) - HCAHPS Overall Patient Rating		73% [75pr]	Feb 2013
HMC Employee Turnover FY13 YTD		5.9%	Mar 2013

Councils
AACS
Acute Care
Critical Care
Pediatrics
Surgical
Trauma
Psychiatry

Services\Depts.
Burn / Plast
ED
Neuroscience
Radiology
Rehab
Vascular
CSS
Nutrition
Pharmacy

Topics
Finance
Infection Ctrl
Hand Hyg
Patient Safety
Mortality
Core Meas
Pt Experience
Turnover
VBP Metrics
UDF
Severity of Illness
Sepsis
E.O.C
Organ Donation

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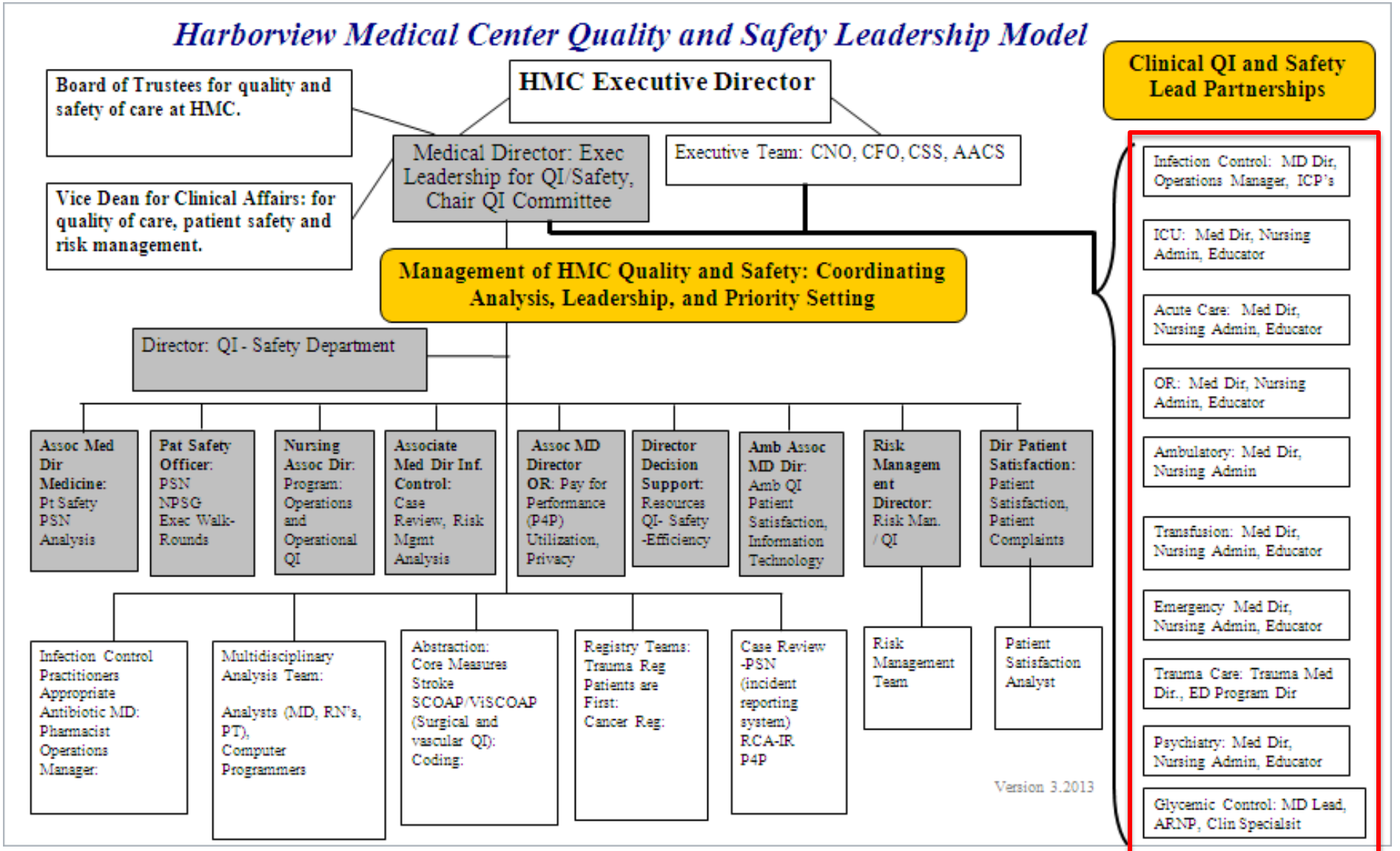
PHYSICIAN-NURSE PARTNERSHIPS



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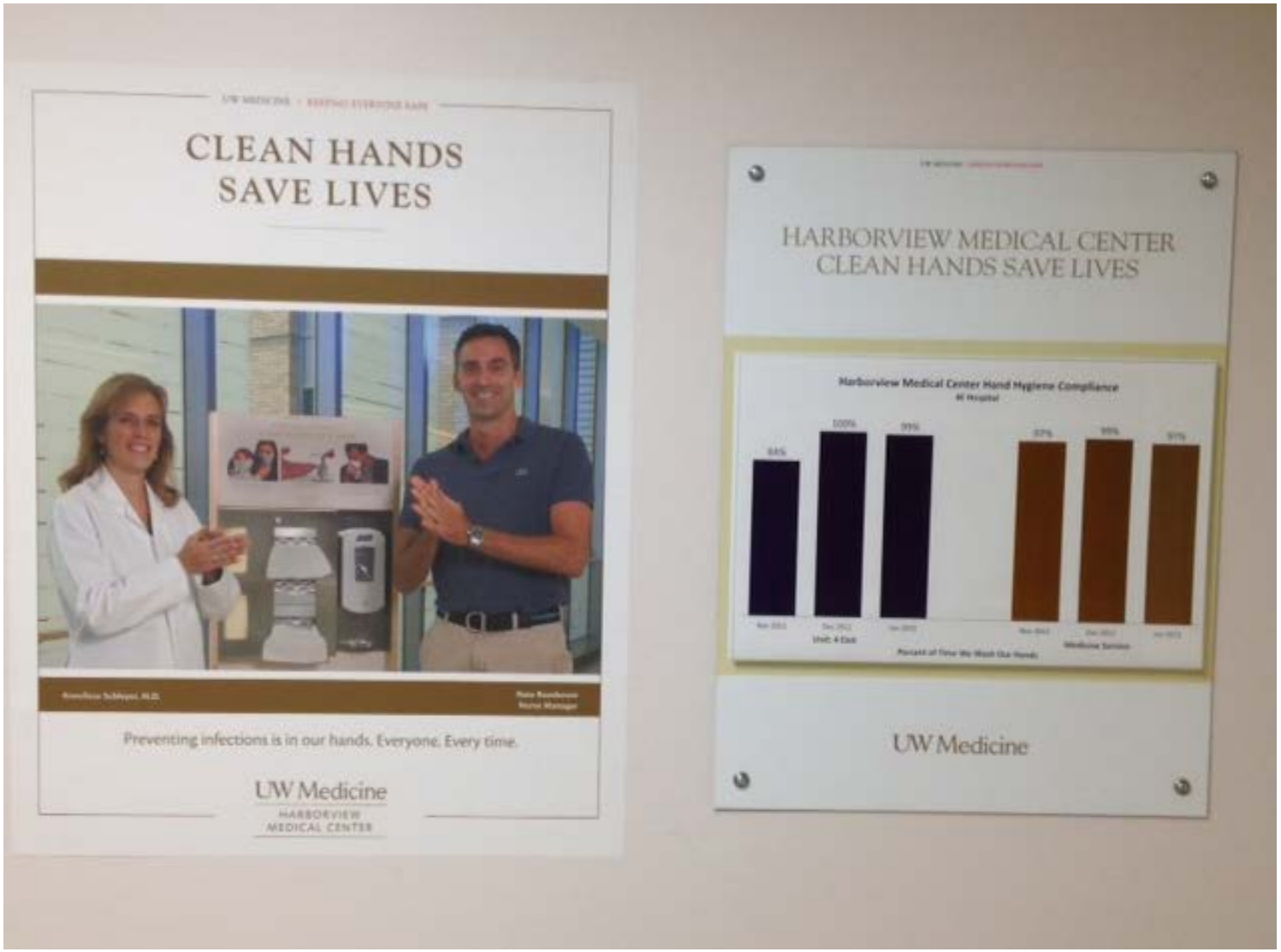
MEDICINE AND 4E HOSPITAL



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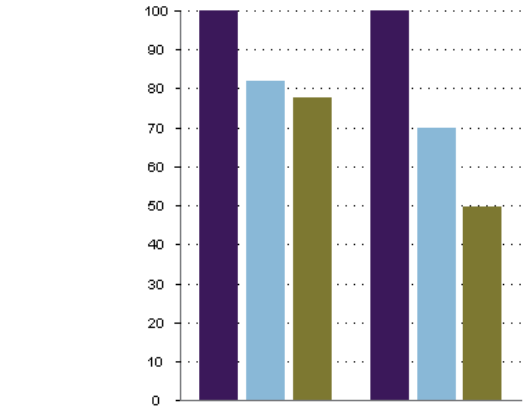
PATIENT SATISFACTION REPORT CARDS

HMC Patient Experience OP CGCAHPS Survey Results (Dept View)
Goss, J Richard (General Internal Medicine)

Overall MD Rating (Dept)
(% Rating 9 or 10 on 10pt Scale)

Jul-Dec 2012



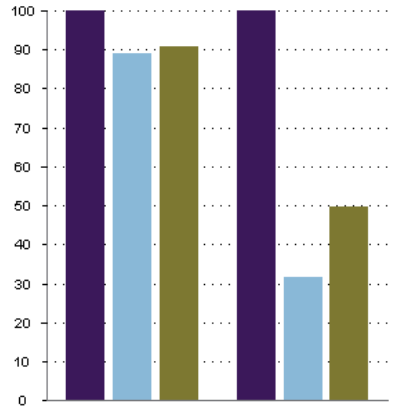
	Percentage(%)	Percentile Rank(pr)
Goss, J Richard (n=2)	100.0	100
General Internal Medicine (n=174)	82.1	70
Goal	78.0	50

CG-CAHPS Satisfaction Survey

MD Communication (Dept)
(% Yes, Definitely to did the doctor explain things in a way that was easy to understand, listen carefully to you, give you easy to understand instructions about taking care of health problems/concerns, seem to know the important information about your medical history, show respect for what you had to say, spend enough time with you)

Detail Chart

Jul-Dec 2012

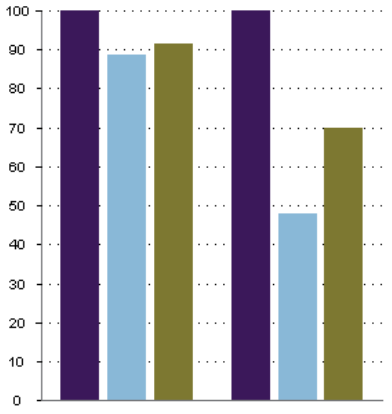


	Percentage(%)	Percentile Rank(pr)
Goss, J Richard (n=2)	100.0	100
General Internal Medicine (n=174)	89.2	32
Goal	91.0	50

CG-CAHPS Satisfaction Survey

Willingness to Recommend (Dept) (Patients Are First Measure)
(% said Yes Definetely would recommend this doctors office to your family and friends)

Jul-Dec 2012



	Percentage(%)	Percentile Rank(pr)
Goss, J Richard (n=2)	100.0	100
General Internal Medicine (n=174)	88.8	48
Goal	91.8	70

CG-CAHPS Satisfaction Survey

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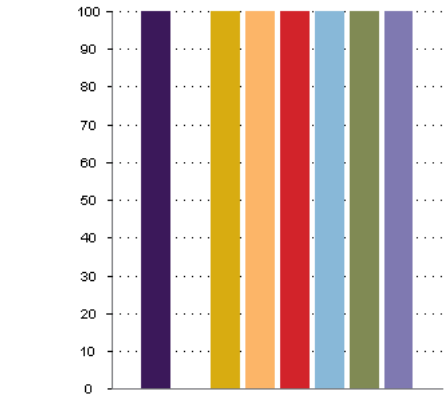
PATIENT SATISFACTION REPORT CARDS

HMC Patient Experience OP CGCAHPS Survey Results (Dept View)
Goss, J Richard (General Internal Medicine)

MD Communication Item Level Detail (Dept)

(% Yes, Definitely to did the doctor explain things in a way that was easy to understand, listen carefully to you, give you easy to understand instructions about taking care of health problems/concerns, seem to know the important information about your medical history, show respect for what you had to say, spend enough time with you)

Jul-Dec 2012



	Percentage(%)
MD Communication (n=2)	100.0
Explain Things	100.0
Listen	100.0
Enough Time	100.0
Easy Instructions	100.0
Know Medical History	100.0
Show Respect	100.0

CG-CAHPS Satisfaction Survey

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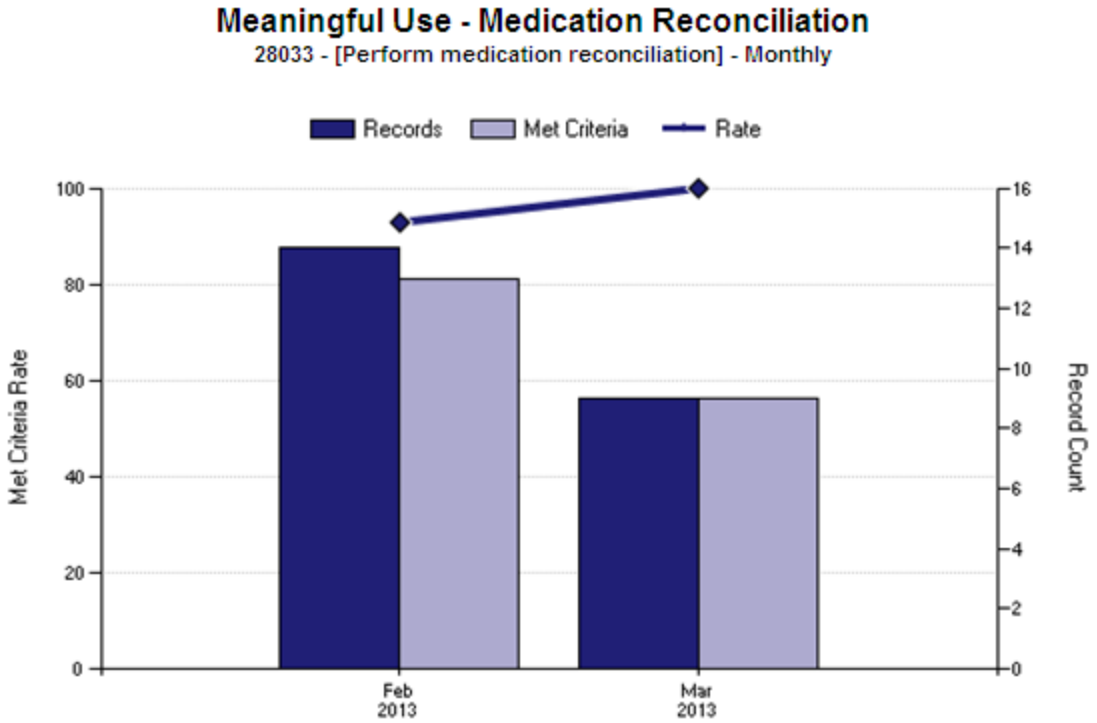
MEANINGFUL USE –EH METRICS

Med Rec

- Facilities
- Departments
- Units
- Individuals
- TimeFrame
- Compare



	Feb 2013	Mar 2013
Rate	92.9%	100.0%
Met Criteria	13	9
Records	14	9

Definition: The eligible hospital or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.

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MEDICAL QUALITY IMPROVEMENT COMMITTEE

- Multidisciplinary peer-review of cases with quality of care concerns
  - QI representatives from each clinical service
  - Patient Care Services
  - Pharmacy
  - Patient Safety
  - IT/CPOE
  - QI/Risk Management
- Prompt mortality review
- Patient safety indicator review

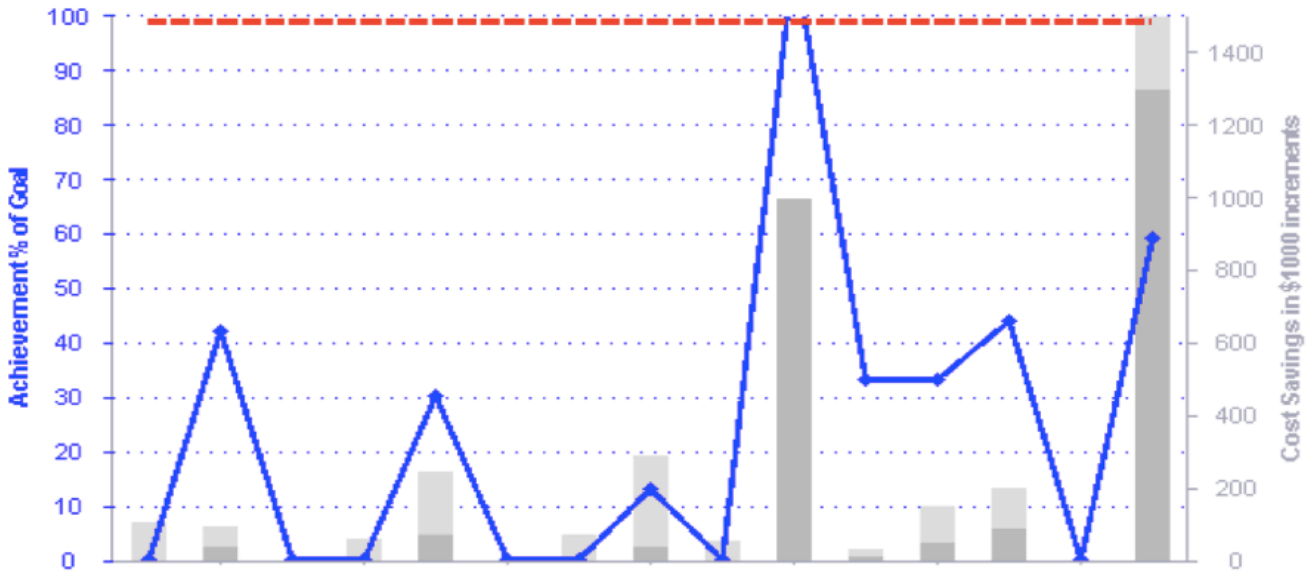
MQIC PARTICIPATION MATRIX
JANUARY 2009 –MARCH 2013

Service	*Service Rep*	*Attendance at MQIC*	*Service Report* *Turned in on time* / *Presented On Schedule* / *Presented in person*		
Anesthesiology	E Pavlin	core		B	
Emergency Trauma Ctr	A Betz	core		A	
Family Medicine	J Huntington			C	
Medicine	A Schleyer	core		C	
Neurology	WT Longstreth	core		B	
Stroke	WT Longstreth	core		B	
Epi	WT Longstreth	core		B	
Neuro Surgery / NIR	L Kim	core		B	
Neuro Critical Care	C Lay			B	
OB GYN	K Shy			C	
Ophthalmology	P Chen			C	
Oral Surgery	J Dillon			C	
Ortho Surg/Foot/Ankle	D Beingessner	core		A	
Ortho Spine	R Bransford			B	
Otolaryngology	M Whipple			C	
Pathology	S Schmechel			C	
Pediatrics	B Johnston			C	
Plastics/Hand	J Friedrich			C	
Psychiatry	M Snowden			C	
Radiology	B Lehnert	core		B	
Diagnostic Neurorad	B Lehnert	core		B	
Nuclear Medicine	B Lehnert	core		B	
Interventional Rad	W Monsky			B	
Rehabilitation Med	J Friedly			C	
Surgery	L McIntyre	core		A	
Thoracic Surgery	T Varghese			A	
Urology	C Yang			B	
Vascular Surgery	N Tran			B	

SURGICAL COUNCIL: PRACTICE VARIATION AND EFFICIENCY

HMC Supply Chain Optimization Scorecard
($1000s) FY11

784



	Burn / Plstc	Gen Surg	GYN	Hand	Neur Surg	OMS	Opht	Orth	Oto	Spine	Urol	Vasc	Ansth	Intrv Rad	FY 2011 Total
Target Achievement %	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%
Achieved % of Goal	0%	42%	0%	0%	30%	0%	0%	13%	0%	111%	33%	33%	44%	0%	59%
Achieved	0	40	0	0	74	0	0	38	0	999	11	49	87	0	1297
Goal - Outstanding	109	55	0	61	171	0	73	251	55	0	22	100	113	0	1010
Goal - Original	109	95	0	61	245	0	73	289	55	898	32	149	200	0	2206
Anticipated	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

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HARBORVIEW MEDICAL CENTER

PROVIDER LEVEL COMPARISONS

McKesson Performance Analytics Explorer™

Overview | Hospital | MS-DRG | UHC Comparison | Cross Population | Physician | Day of Stay | Procedures | Diagnosis | Services | Dept View | Definitions

HMC FY2012 Cases by OMSA Surgeon - Neurosurgery

OR Cases: ☑ Non-OR Cases ☑ OR Cases

ICU Cases: ☑ ICU Case ☑ Non-ICU Case

Return to Overview

1. Choose a Physician Type

Attending Physician
Surgeon of Record

2. Choose Specific Physician

Type to search in list

3. Include Providers with more than

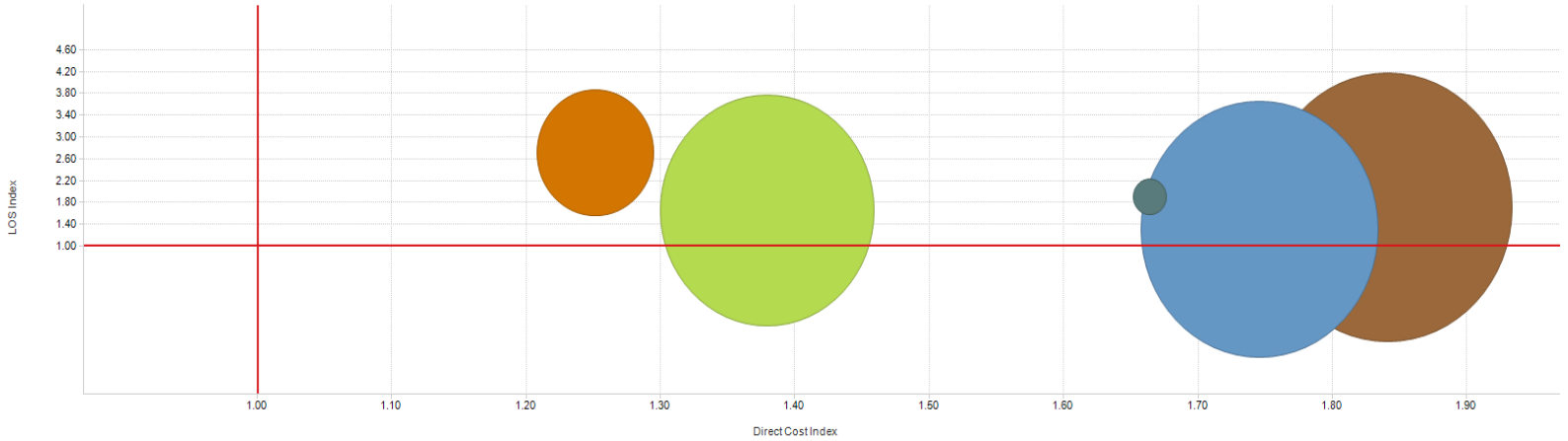
0 Cases

4. Choose MS-DRG

Type to search in list

(All) 110 values
003 - ECMO OR TRACH W MV 96...
020 - INTRACRANIAL VASCULA...
021 - INTRACRANIAL VASCULA...
022 - INTRACRANIAL VASCULA...
023 - CRANIO W MAJOR DEV IM...
024 - CRANIO W MAJOR DEV IM...

MS-DRG Direct Cost Index by LOS Index



FY	Hospital	PhysChoice	Direct Cost Index	Direct Cost/Case	Total Direct Cost	CMI	Cases	Patients	MS-DRG Cost Outlier	Surgical Cases	ICU Cases	ED Cases	30 Day Readmit (All	ALOS	O to E LOS Index	UHC Opport... Cost
2012	Harborview Medical Center		1.91	$71,641	$8,095,404	3.37	113	107	65	93	109	22	9	10.91	1.81	$3,696,208
			1.55	$62,604	$5,196,129	3.88	83	81	42	79	78	48	10	10.87	1.13	$1,599,908
			1.65	$58,428	$6,952,883	3.55	119	114	49	72	116	49	8	7.24	0.94	$1,410,330
			1.27	$66,366	$2,721,017	4.00	41	39	20	36	39	40	3	15.71	1.24	$375,516
			1.25	$45,494	$2,365,688	3.56	52	51	9	50	51	22	3	8.37	0.97	$139,532
Grand total			**1.61**	**$62,086**	**$25,331,120**	**3.61**	**408**	**383**	**185**	**330**	**393**	**181**	**33**	**9.99**	**1.21**	**$7,221,494**

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