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Patient-Centered Care: From Concept to Reality

Lessons from Geisinger and xG Health Solutions

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Your Presenters

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Agenda

1. Explore primary care as a foundation of population health improvement
2. Discuss key components of Geisinger approach to patient-centered medical homes
3. Share learnings and insights on how to accelerate and sustain results in a medical home
4. Discover how to get started and where to focus for early success

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Explore primary care as a foundation of population health improvement

The Importance of Primary Care in Healthcare Transformation

- Quality gaps have been reported in **numerous** published reports
- **Forty percent** of people with chronic illness in the United States have not received agreed-upon standards*
- Gaps are **present** in various practice settings
  - Academic and private practice
  - Specialist and primary care
  - Fee for service and managed care

Not primarily due to a subset of underperforming doctors...but rather a system problem

*Internet Citation: Rand Corporation report in The New England Journal of Medicine. **June 2003;** http://www.nejm.org/doi/full/10.1056/NEJMsa022615

The Geisinger Approach to Primary Care

- Geisinger has long **realized the importance** of primary care
- They tested multiple approaches and created their own model focused on driving improvements in outcomes
- The Geisinger Model – known as "Proven Health Navigator"
  - Launched in 2006
  - Improved coordination of care
  - Enhanced patient access
  - More effective and efficient disease and case management

…all of which contribute to a decrease in avoidable hospitalizations and positive ROI (1.7X ROI on medical homes as reported in The American Journal of Managed Care)

*The American Journal of Managed Care website online March 16, 2012. Authors include Janet Tomcavage, Fred Bloom, and Glenn Steele.

The Geisinger Components of the Advanced Medical Home

Patient Centered Primary Care Design	• Primary Care Physician led team-delivered care • Care team members functioning at “top of the license” • Monthly Care Team meetings
Population Specific Care Management	• Population identification, segmentation and risk stratification • Manage both high risk and lower acuity and well population • Embedded case management approach for high risk
Medical Neighborhood	• 360°care - SNF, ED, hospitals, home health, pharmacy, etc. • High value referral systems across full continuum of care • Transitions of care across care settings
Performance Management	• Patient and clinician satisfaction • Cost of care, utilization, efficiency • All-or-none sets of performance measures
Value-Based Reimbursement	• Fee-for-service with P4P payments for quality outcomes • Total cost of care (PMPM) targets • Payments aligned with measured performance metrics

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Discuss key components of Geisinger approach to patient-centered medical homes

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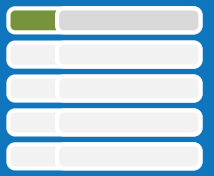
Patient-Centered Primary Care Redesign



Eliminate | Automate | Delegate | Incorporate | Activate

- Physician-led, team-based care
  - Physician leadership must set stage for expectation of practice
  - Responsibility and awareness of where patient is at all times – hospital, skilled nursing facility, home
- Best Practice Team
- Chronic disease and preventive care optimization via IT-enabled planned visits

Patient-Centered Primary Care Redesign

Monthly Care Team Meetings

- Foundation of success
- Shared leadership
- Case review
- Workflow gaps and redesign
- Performance monitoring
- Care team training

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Advanced Case Management
Our Approach

High-risk Identification

- Predictive modeling
- EHR data
- Medical claims
- Pharmacy data
- Health Risk Assessment (HRA) data

Targeted Populations

- HF, COPD, oncology
- Special populations – cystic fibrosis, CP, MS, high risk pregnancy
- Multiple trauma
- ESRD, frail elderly
- TOC

Comprehensive Assessment

- Driving issue behind case
- Physical and psychosocial gaps
- Readiness to change
- Family/social supports
- Frequent follow-up with patient/family

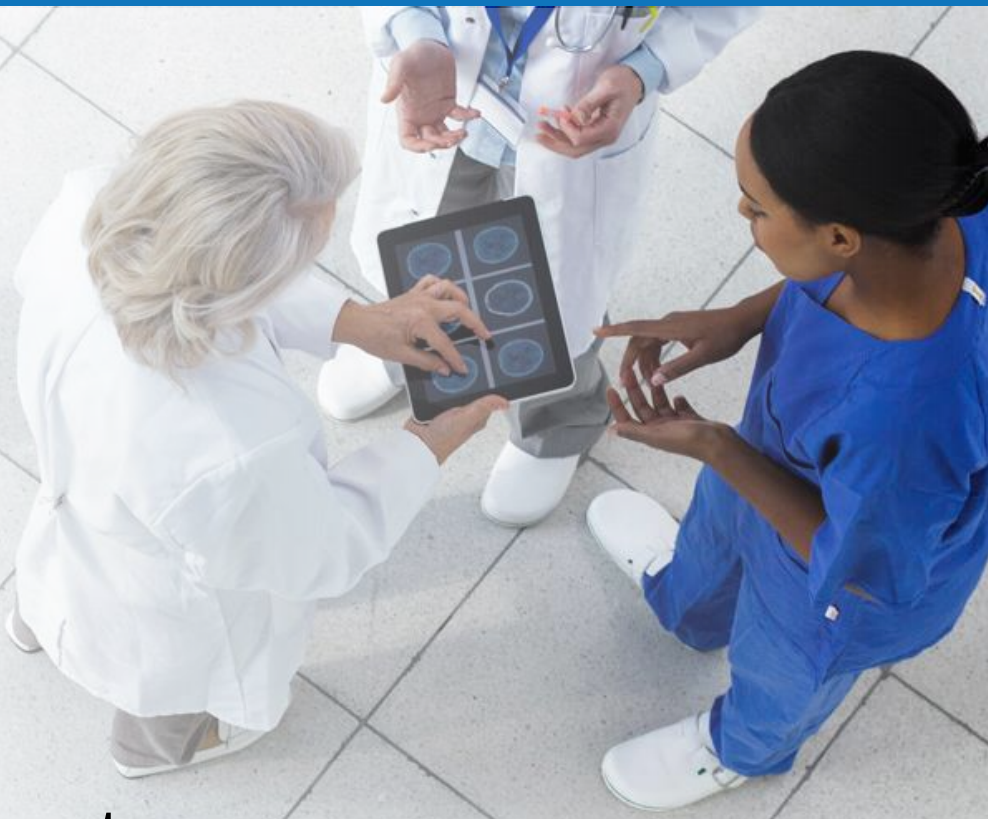
Team Care

- Daily interaction with provider
- Active team member
- Patient sees CM in practice or with specialist
- Pushes access and exacerbation management

Advanced Case Management
Embedded Case Managers

- In-depth training to prepare Case Managers
- Acuity/complexity of patients being managed
- Staffing ratio
- Typical caseloads

The Geisinger Model for Condition Management



- Embedded Health Managers
  - Condition Screenings
  - Symptom Monitoring
  - Medication Management
  - Patient activation and engagement
- Focus on those at moderate and high risk—not at goal
- Quality/HEDIS

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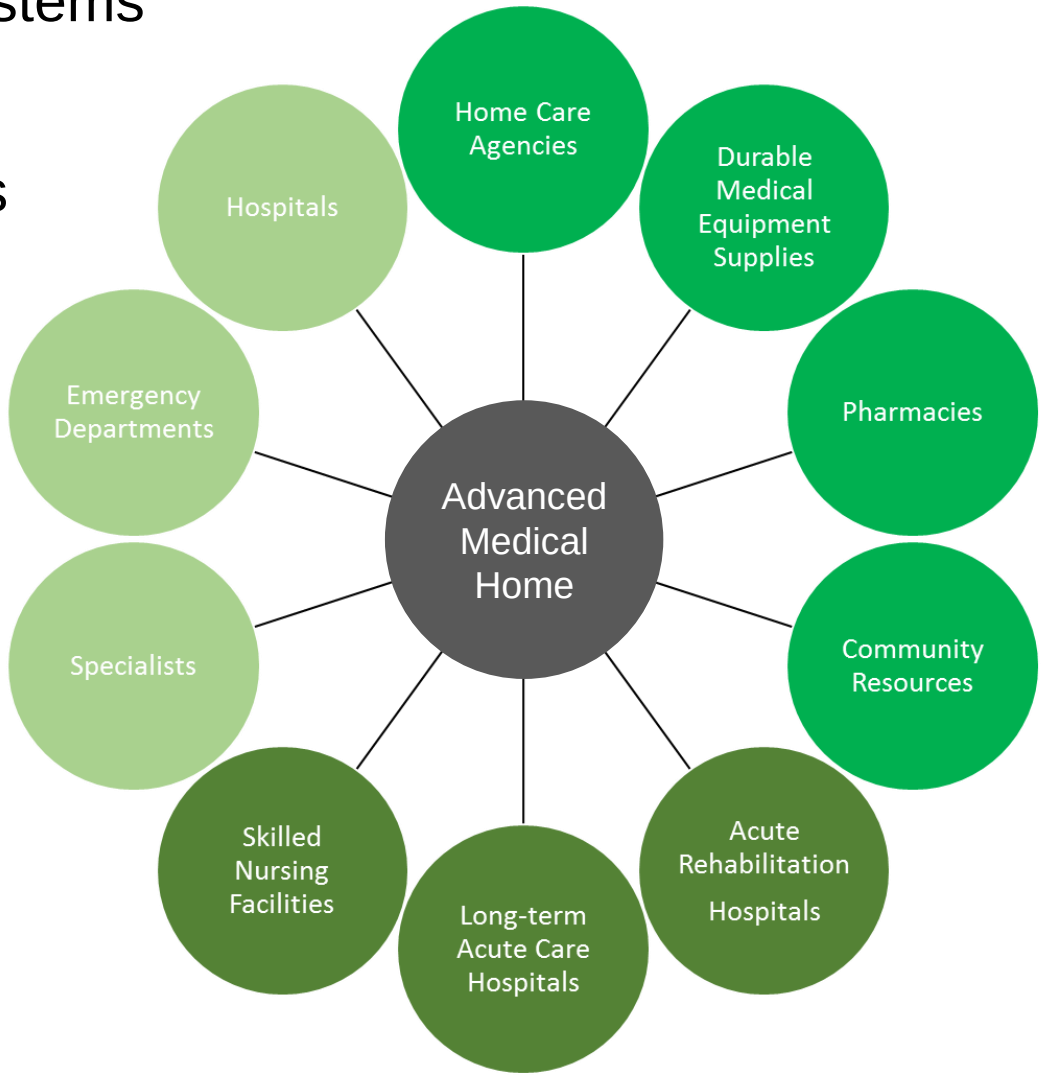
Medical Neighborhood

- Micro-delivery referral systems
  - High-volume specialties
- 360-degree care systems
  - Hospital care
  - Home health
  - Skilled nursing facility
  - ER coverage
  - Community resources



Geisinger Tactics/Strategies for Transitions of Care

Tactic	Care Setting
Readmission risk screening	Inpatient
Risk Assessment and Prediction Tool (RAPT)	Outpatient
Interdisciplinary Team Rounds (IDTs)	Inpatient
Teach back	Inpatient
Embedded scheduler	Inpatient
Kitchen Table Program®	Home

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Right Information, Right Decisions

- Identify vital information crucial to managing the most cost-effective, accountable, high-quality, patient-centered healthcare
- Integrating data, performing analyses, and interpreting results from the clinical, financial, and operational domains
- Clear, actionable insights on trends, performance measures, and opportunities for improvement

Success Depends on Data, Analytics, and Interpretation Coming Together

Clinical and analytical teams partner to drive insights and action

ANALYTICS SERVICES

Goal: Value Based Reimbursement success enabled through transformational decision support

Cost and utilization analytics	Clinical quality analytics	Provider performance analytics	Bundled payment analytics	Multi-player analytics
Provide insights into financial performance and target areas for improvement	Monitor care quality and drive patient interventions	Understand variations in provider quality and efficiency and enable improvement	Encourage care coordination, reduce costs, and drive financial success	Simplify provider operations and strengthen insights for payer negotiations

Data integration and business intelligence tools

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Share learnings and insights on how to accelerate and sustain results in a medical home

Lessons Learned Along the Way

- It is possible to improve healthcare while reducing costs
- Important to have engaged Physician & operational leadership
- Having data up front is crucial but not always a show-stopper
- Implementation of a Best Practice Team is necessary
  - Proper staff allocation
- Dedicated Case Managers are vital
- Proper training is essential for all those involved in the Advanced Medical Home
- Not just reengineering – this is for the “long haul”
- Strong infrastructure with guidelines for accountability

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How to get started and where to focus for early success

How to get started

- Determine current state with a baseline evaluation
- Develop a customized approach and work plan
- Prioritize based on core attributes of a mature Advanced Medical Home
- Begin to understand your data and how to interpret it clinically

Geisinger and xG Health Patient-Centered Medical Home Experience

Sponsor	Number of Sites
Geisinger (owned, in PA)	42
Non-Geisinger (in PA)	40
WVU Healthcare	3
EMHS	9
Bon Secours Health System	21
Hospital Sisters Health System	11
Taconic IPA	10
Community Hospitals of Monterey	3
TOTAL	**139**

Key Determinants of Health System Success Under Risk-Based Payment

Workflow	**Electronic Health Records**	**Performance Management**
Care Design • Primary • Hospital & Specialty	**Risk-Based Payment Health System**	**Informatics & Technology**
Culture	**Management Structure**	**Quality of Care**
	Value-based Reimbursement	

Determining Your Baseline

- Learn where you are today
- Establish your goal
- Determine next steps
- Create a plan

Example: *Clinical Workflow Maturity Grid*

1	2	3	4	5
No formal workflow improvement plan in place	Plans for protocols, practice standards and workflow improvements	Protocols and workflows in place; unsure of reliability of use or integration across full organization	Consistent practice standards and workflows linked to goals and organizational strategy	Protocols, practice standards and workflows with reliable and consistent results that illustrate progress toward goals

Transformation to value-based care is not a project. It's a continuous process– a new mindset, a culture change, and a lifestyle commitment.