

Physician Leaders Rise to Meet Challenges as a Safety-Net Health System Moves from Volume to Value

Becker's Health IT + Clinical Leadership 2019

CMO: Jeffrey Arnold MD; CMIO: Philip Strong MD

County of Santa Clara Health System

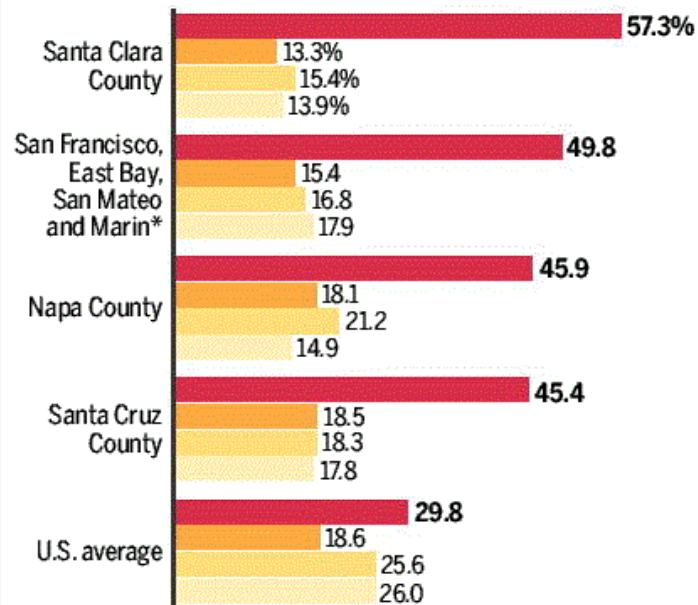
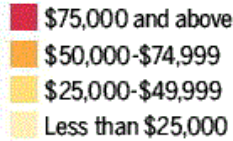
San Jose, CA

A Safety Net System in Silicon Valley

Soaring wealth but widening income gap

The Bay Area has some of the highest median household incomes in the country, but the region also has a widening gap between high earners and other workers.

Household incomes

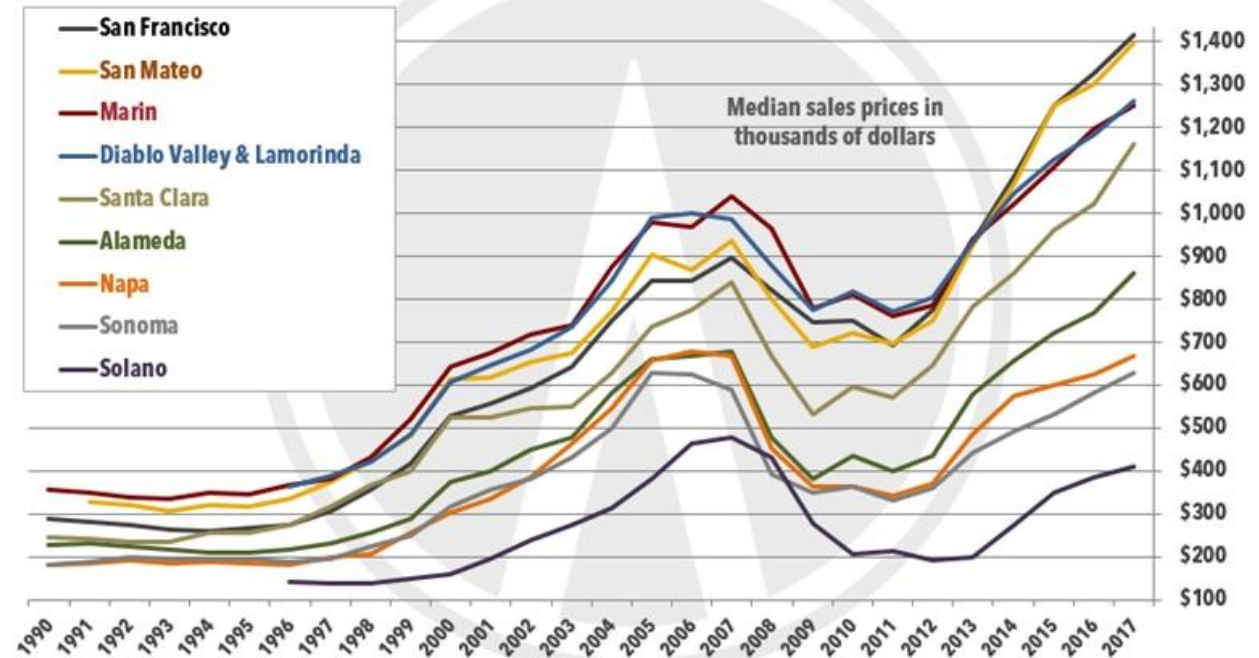


*Consists of San Francisco, Alameda, Contra Costa, San Mateo and Marin counties

Sources: U.S. Conference of Mayors, IHS Global Insight

BAY AREA NEWS GROUP

Median Bay Area House Prices Single Family Home Sales, 1990 - 2017



Median prices disguise an enormous variety of prices in the underlying individual sales. Data from the California Associations of Realtors Annual Historical Data Summary and local MLS associations. Deemed reliable but may contain errors and is subject to revision. All numbers should be considered approximate.



PARAGON
REAL ESTATE GROUP

A Safety Net System in Silicon Valley

- San José 2012 median income:
\$76,000 (U.S. \$51,000)
- 45% of Santa Clara County
households make more than \$100,000
- 33.5% of households in Santa Clara County earn below the living wage
- Fourth largest number of homeless individuals of all U.S. metro areas
(6,681)

County of Santa Clara Health System

Our Mission:

Provide high quality, compassionate, and accessible healthcare for all persons in Santa Clara County regardless of their social-economic status and ability to pay

Our Vision:

“Better Health for All”

Santa Clara Valley Medical Center

(Delivery network: Hospital & Clinics)

Santa Clara Valley Medical Center (Hospital)

Clinics/Health Centers

Valley Health
Center Downtown

Valley Health
Center Bascom

Valley Health
Center East Valley

Valley Health Center
Gilroy

Valley Health
Center Milpitas

Valley Health
Center Moorpark

Valley Health Center
Sunnyvale

Valley Health
Center Tully

Valley Health
Center Alexian

Valley Health Center
HomeFirst

Valley Health
Center Lenzen

Valley Specialty
Center

Present/Future Growth & Development

O'Connor Hospital

St. Louise Hospital

OCH
Subacute

DePaul
Urgent Care

Public-Private Partnerships

Community
Health Centers

Behavioral
Health

Some Kind of
APM?

Santa Clara Valley Medical Center

- We ARE Santa Clara County’s Public Safety Net Health System
 - Largest public hospital system in Bay Area/Northern CA
- 574 Bed Tertiary Level Care Medical Center and 11 Community Based Clinics
 - Accredited by The Joint Commission
 - ACS Verified as Level 1 Adult Trauma and Level 2 Pediatric Trauma
 - CARF Accredited Inpatient and Outpatient Rehabilitation Services
 - ACS Verified Burn Care Center
 - High risk Neonatal Intensive Care Unit (NICU) – CCS Region
 - LGBT Healthcare Equity Designation: Leader status (2016)
 - HIMSS Stage 7

(CY 2018 Data):

- Operating Budget: \$1.8 B
- FTE/Employees: > 6,000
- Volunteers: > 500
- Languages spoken: > 150

(CY 2018 Data):

- Individuals Served Annually: 275,000
- Daily Census in Hospital: 375
- Births: Over 3,200
- Surgeries: Over 10,000
- ED/Outpatient Visits: 800,000

Santa Clara Valley Medical Center

A Teaching Hospital for Physicians:

- Four ACGME* accredited residency programs (110 residents/year) at SCVMC
 - Internal Medicine (three-year program & one-year preliminary program) – 60 residents
 - Ob/Gyn (four-year training program) – 16 residents
 - Radiology (four-year program) – 18 residents
 - Transitional (one-year program) – 16 residents
- Stanford Medical Students: 200-210 Students per year
 - Emergency Medicine, Surgery, Pediatrics, Orthopedics, Neurology, etc.

*Accreditation Council for Graduate Medical Education (ACGME)

Hospital System Overview – FY2018

Metric	SCVMC	OCH	SLR	Total
Licensed beds	574	358	93	1,025
Patient days	120,376	45,046	10,948	176,370
ADC	363	123	30	516
Births	3,087	1,631	346	5,064
ED Visits	88,856	51,948	29,556	170,360
Staff headcount	6,000	1,300	400	7,700

County of Santa Clara Health System: Advantages

- Mature EHR Implementation from a single vendor
 - Achieved HIMSS Stage 7 Certification (inpatient and outpatient)
 - Enterprise Data Warehouse (EDW) built around same vendor
- Custody (county jail) went live on same platform (as inpatient facility)
 - All custody patients are registered in the EHR
 - All custody patients are screened on intake: Substance Use Disorder (SUD), Serious Mental Illness (SMI), Chronic Health Problems/Medications
- Progressive Valley Homeless Healthcare Program (VHHP)
 - Serves a large base of patients adversely affected by social determinants of health (SDOH)
- Willing to bring Behavioral Health Services (BHS)/Substance Use Treatment System (SUTS) providers on a common platform county-wide

Background

Thanks to ARRA & HITECH -> marked nationwide increase in EHR adoption

- At SCVMC, this has been underway > 10 years. We recently celebrated the 5 year anniversary of our HealthLink (Epic) EHR implementation

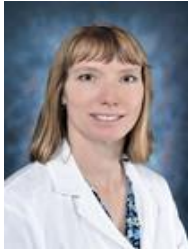
EHR usability is an on-going issue

- Recognized as a significant (but not the ONLY) factor in (physician) burnout and poor (nursing, therapy, etc.) employee engagement
- The situation at SCVMC/HHS led to the rise of Physician Builders locally
- And over the last year, the development of a “provider optimization” program: HAPPI ...

Physician Informatics Team: Active Clinicians With Informatics Involvement



Michael Hwa, M.D.
Inpatient Champion



Andrea Cervenka, M.D.
Adult Primary Care



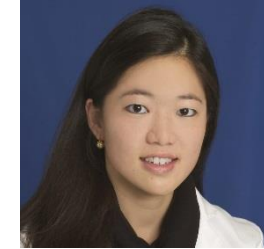
Quynh Pham, M.D.
OB-GYN



Dan Vostrejs, M.D.
Pediatrics



Jenni Djafari, M.D.
Pediatrics & E-Health



Cheryl Pan, M.D.
Op Time Champion



Jason Williams, M.D.
Gastroenterology



Alex Chyorny, M.D.
Custody



Albert Chiang, M.D.
Anesthesia



Sharmila Pramanik, M.D.
Pathology and Lab



Snehal Adodra, M.D.
Radiology

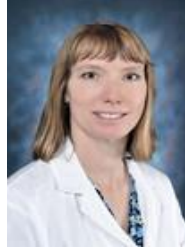
Physician Informatics Team: ABPM Clinical Informatics Board Certified



Philip Strong, M.D.
C.M.I.O



Michael Hwa, M.D.
Inpatient Champion



Andrea Cervenka, M.D.
Adult Primary Care



Quynh Pham, M.D.
OB-GYN



Dan Vostrejs, M.D.
Pediatrics



Jin Hahn, M.D.
Pediatric Neurology



Sunshine Pooley, M.D.
Neonatology



Jennifer Tong, M.D.
Hospital Medical Director

Physician Informatics Team: 50%-time Informatics



Sean Gaskie, M.D.
Family Medicine



Jin Hahn, M.D.
Pediatric Neurology



Sunshine Pooley, M.D.
Neonatology



Sneha Kapur M.D.
Internal Medicine



Jesus Saucedo M.D.
Family Medicine/ED

How/Why Did This Develop?

- Prior to Epic implementation providers saw the need for direct physician involvement in clinical content development and workflows
- Dr. Jennifer Tong was approached 6 months (end of 2012) prior to SCVMC Epic go-live to develop order sets: “because this was required by the vendor”
- She started this, and recruited others to come alongside because: “without direct physician participation, there would be no clinical content”
- They also realized that the EHR implementation had workflow implications
- And that their best shot at having a positive impact on this was from within the “build team”:
 - Seeing what was coming
 - And providing constructive alternatives for improvement

And So ...

Why Doctors Hate Their Computers

Digitization promises to make medical care easier and more efficient. But are screens coming between doctors and patients?

[Atul Gawande](#)

On a sunny afternoon in May, 2015, I joined a dozen other surgeons at a downtown Boston office building to begin sixteen hours of mandatory computer training. We sat in three rows, each of us parked behind a desktop computer. In one month, our daily routines would come to depend upon

Gawande, Atul. “Why Doctors Hate Their Computers”, The New Yorker, November 12, 2018.

Six Vignettes

- Physicians in End-User Training
- Revenge of the Ancillaries
- Susan Sadoughi: an office-bound colleague – and “the Tar Pit”
 - Problem list: a “hoarder’s stash”
 - Clinical notes: -> “long, ... deficient, ... redundant.”
 - Inbasket: “clogged to the point of dysfunction.”
 - Brings up Mayo study: “... one of the strongest predictors of burnout was how much time an individual spent tied up doing computer documentation.”
- Gregg Meyer (chief clinical officer): “It is for the patients.”
- Medical scribes (e.g. Alan Gorroll): the good and the not-so-good
- John Cameron, construction supervisor who “gets it”.

Some Observations

- 3 years is "early" for an Epic implementation
- Optimization is **critically important** if we're going to get to "the long game"
- I don't doubt that computer documentation time is "strongest predictor of burnout"; emphasizes need for optimization. I believe there <may be> a cause-effect confounder.
- Something we can get behind: **it's for the patient**. But this is complicated, and fulfilling the quadruple aim makes doing things for patients sustainable. Who knew?
- Flip side of the Mayo study: extent of involvement in EHR personalization inversely proportional to self-reported burnout

Furthermore ...

IDEAS AND OPINIONS

Annals of Internal Medicine

Physician Burnout in the Electronic Health Record Era: Are We Ignoring the Real Cause?

N. Lance Downing, MD; David W. Bates, MD, MSc; and Christopher A. Longhurst, MD, MS

Physician burnout is reaching crisis proportions in the United States (1). Studies have noted a rising prevalence of emotional fatigue. One study suggested that more than half of physicians in some disciplines are burned out and that this proportion is increasing. The number of clinicians leaving the workforce represents a major concern to health care professionals and to the health of the nation. Many factors contribute, but the physician's interaction with electronic health records (EHRs) is especially important now that EHRs have been broadly adopted across the country.

justify billing to such payers as the Centers for Medicare & Medicaid Services, physicians must specify diagnoses from long and confusing arrays of choices relating to each test or procedure and document a clinically irrelevant number of elements for the history of present illness, review of systems, and physical examination. Documentation requirements in the United States are a relic of fee-for-service and will make even less sense as we move to new payment mechanisms.

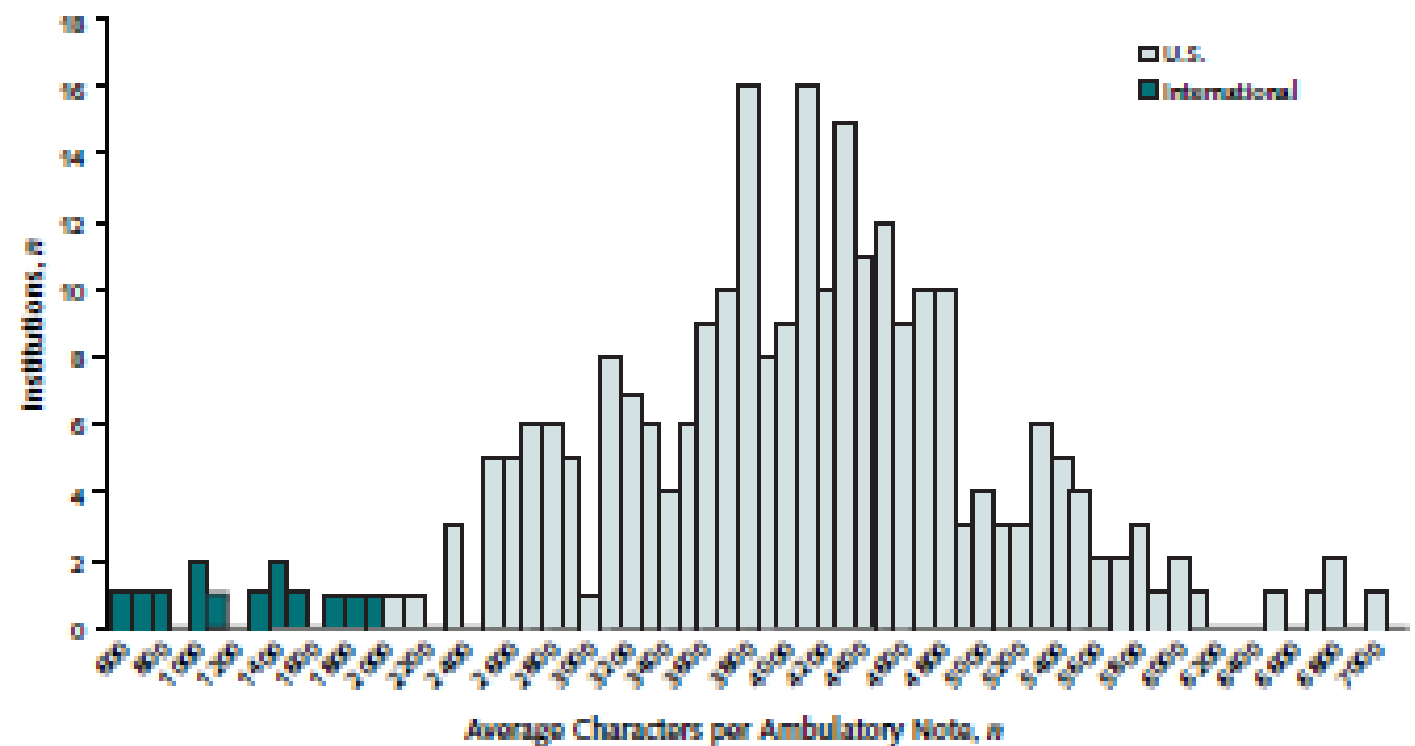
The movement toward a value-based payment system alone will not ameliorate the effect of documents.

Downing L, et al.

“Physician Burnout in the Electronic Health Record Era: Are We Ignoring the Real Cause?”. Ann Int Med. 169(1): Pp 50-51, July 3, 2018.

US vs. International Ambulatory Documentation

Figure. Average characters per ambulatory progress note in U.S. and international health systems.



Column height represents number of organizations. Dark columns represent 13 organizations outside the United States (140 000 notes from Canada, the United Kingdom, Australia, the Netherlands, Denmark, the United Arab Emirates, and Singapore). Light columns represent 254 organizations in the United States (10 million notes).

Downing L, et al. “Physician Burnout in the Electronic Health Record Era: Are We Ignoring the Real Cause?”. Ann Int Med. 169(1): Pp 50-51, July 3, 2018.

Documentation Requirements: A Marker?

- EHR Vendor priorities
- Revenge of the Ancillaries
- Revenge of the Payers (especially CMS)!
- Going to get worse as a consequence of value-based care?

We believe that platform improvements are essential but will be insufficient to address a key cause of physician burnout: our outdated regulatory requirements. Value-based reimbursement programs hold the most promise for controlling spiraling costs, but they must avoid overburdening physicians with administrative responsibilities. Regulatory reform (including changes to billing requirements) allowing clinicians to strip documentation to bare essentials would improve accuracy, enable better use for research, and reduce the tedious work that occupies so much of our time. The nation's shift toward value-based care is welcome, but physician burnout is also a critical priority—we risk losing many physicians if the root causes are not addressed.

Value-Based Care: A Working Definition

“In value-based care, health systems take on greater financial risk for the provision and quality of services.

“Public health care systems in-particular have been demonstrating this approach in Medi-Cal managed care, which has led to increased collaboration with health plans to better align managed care payments with quality and efficiency.”¹

¹“California's Public Health Care Systems' Journey to Value-Based Care” CAPH/SNI Brief: Journey to Value Based Care. from CAPH/SNI website www.safetynetinstitute.org, March 2019.

Value-Based Care Terminology

Term	Definition +/- Examples
CMS: MU -> MIPS	Center for Medicare and Medicaid Services: federal agency. Meaningful use (MU) defined in stages, but now migrated into the Merit-based Incentive Program System (MIPS). MIPS has 4 axes – quality, cost, interoperability,, administration; (+) and (-) incentives – but (-) most prominent. Over 5 years, axis weights will move to quality (30)%, cost (30%), administration (15%), interoperability (15%).
CMS: Core Measures	From CMS: multiple metrics spread across 8 domains, process and outcomes measures: all-cause readmissions, use of medications for specific conditions (for which there is good evidence), control of hypertension, diabetes, preventive care: immunizations, screening, AMI mortality, etc. Overlaps NCQA
CMS: APMs	From CMS: Alternative Payment Models. These include BPCI, ACO, etc.
ONC: CEHRT	Office of the National Coordinator (ONC): Established with the HITECH act, responsible for evaluating and issuing Certifications of Electronic Health Record Technologies (CEHRT), advising CMS on policy implications for health information technology.
TJC: NPSGs	The Joint Commission (formerly JCAHO). A not-for-profit organization responsible for “accrediting” hospital. Conducts “surveys”, can mandate improvements before granting accreditation. The steward for National Patient Safety Goals (NPSGs): SSI, CLABSI, CAUTI, Handwashing, proper patient identification, medication administration
NCQA: HEDIS	National Committee for Quality Assurance: the metric steward for “HEDIS”, the Healthcare Effectiveness Data and Information Set: 83 measures over 5 domains: effectiveness, access, experience, utilization and resource use, health plan descriptive information.

Value-Based Care Terminology - California

Term	Definition +/- Examples
DHCS	Department of Health Care Services (California): Licenses hospitals; helps define and monitor performance and distribute payment for the MediCal program
FQHC	Federally-Qualified Health Center: allows significantly better Medi-Cal fee-for-service payment rates
DPHs	Designated Public Hospitals (DPHs): the UCs, and most county health systems (including SCVMC).
1115(a) Waiver	“Section 1115 of the Social Security Act gives the Secretary of Health and Human Services (HHS) authority to waive provisions of major health and welfare programs authorized under the Act, including certain requirements in Medicaid” ... to do creative things, like pay-for-performance programs
DSRIP	Delivery System Reform Payment Incentives, the first of the 1115(a) Waiver program: process and outcomes measures in several categories for DPHs: infrastructure development, preparation for HC reform, enhance capacity for population-based health management, etc.
Waiver 2020	Successor to DSRIP, 4 distinct programs in which DPHs may participate: PRIME (Public Hospital Redesign and Incentives in Medi-Cal), GPP (Global Payments Program), WPC (Whole Person Care), DTI (Dental Transformation Initiative); finishes at the end of 2020.
MCR: QIP/EPP	Managed Care Rule (MCR) specifies large pool of dollars to be spread among the 21 DPHs that care for Medi-Cal managed care patients. SCVMC annual shares: Extended Payment Program (EPP) - \$100M; Quality Incentive Program: (QIP) \$45M. Possible successor to Waiver 2020.

The SCVMC Experience: Moving from FFS -> Value Based Care

Revenues:

For FY2019, we expect >\$300M from these programs:

- PRIME – 58 Metrics; mostly P4P
- GPP – we get “points (that translate into \$\$) for services to the uninsured
- WPC – A broad array of programs and services targeting “high utilizers”: we enroll in programs but get paid for services
- QIP/EPP (the new kid on the block) – QIP: 21 metrics; that start as P4R but transition to P4P after the first year; EPP: money proportional to MCMC claims; expected to last > 5 years

That is ~20% of overall patient care revenues (\$1.6B)

Where does this end? How did physicians at SCVMC respond?

The Problem

Achieving up to 58 different Pay for Performance metrics established by MediCal for PRIME could equate to over \$50M per year x 5 years in revenue

Our Solutions:

(1) Data Governance

PRIME Project 1.2 Ambulatory Care Redesign: Primary Care
PRIME Reporting Manual V1.0 for Mid-Year Reporting, February 2017
DY 12 Mid-Year Report, Measurement Period 1/1/16 - 12/31/16

Population Criteria

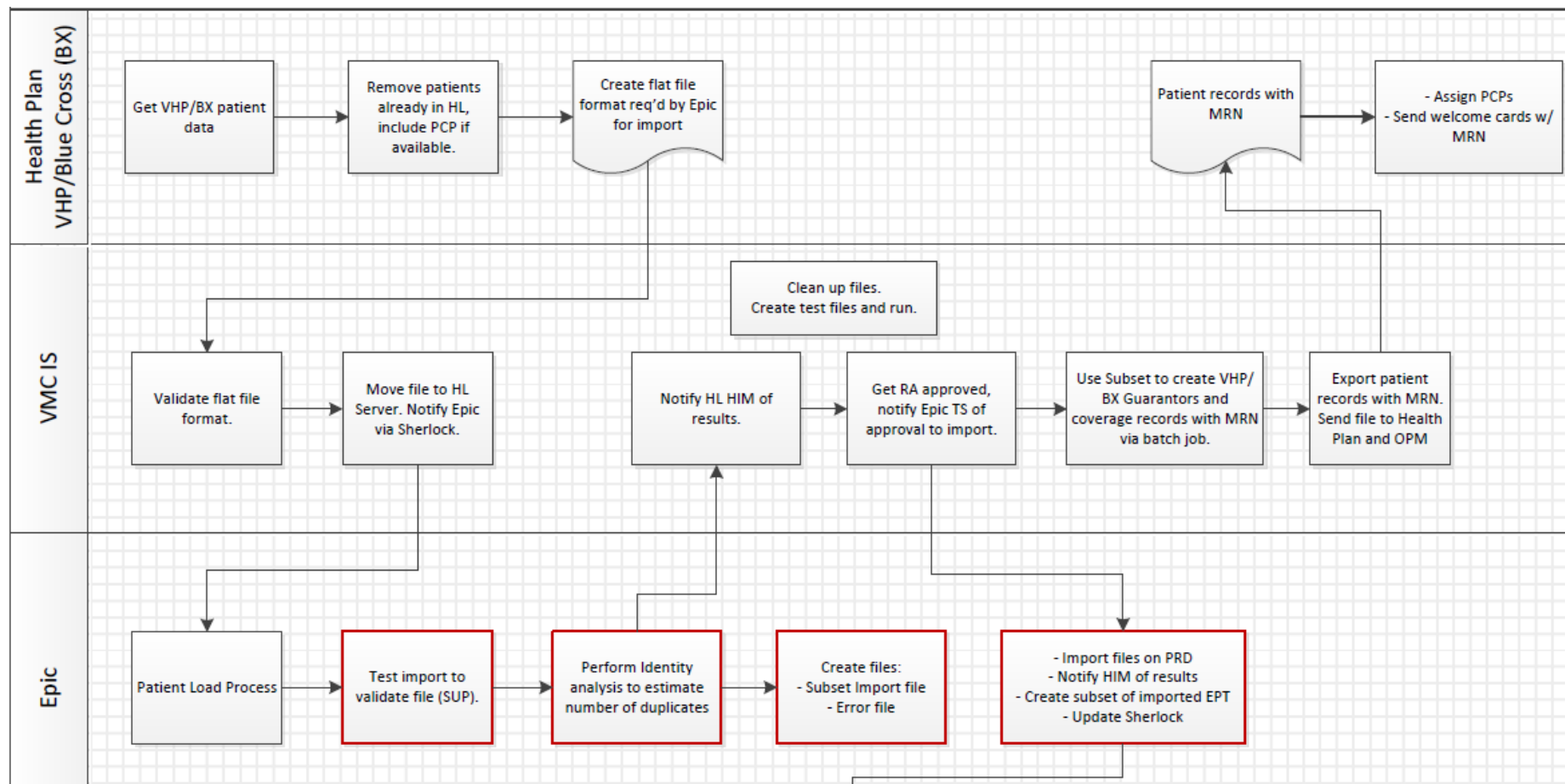
- **Initial Population =**
 - AND: PRIME Eligible Population
 - AND: Age >= 50 year(s) at: "Measurement Period"
 - AND: Age < 75 year(s) at: "Measurement Period"
 - AND: Union of:
 - "Encounter, Performed: Office Visit"
 - "Encounter, Performed: Face-to-Face Interaction"
 - "Encounter, Performed: Preventive Care Services - Established Office Visit, 18 and Up" "Encounter, Performed: Preventive Care Services-Initial Office Visit, 18 and Up"
 - "Encounter, Performed: Home Healthcare Services"
 - "Encounter, Performed: Annual Wellness Visit"
 - during "Measurement Period"
- **Denominator =**
 - AND: Initial Population
- **Denominator Exclusions =**
 - OR: Union of:
 - "Diagnosis: Malignant Neoplasm of Colon"
 - "Procedure, Performed: Total Colectomy"
 - starts before end of "Measurement Period"
- **Numerator =**
 - AND: Union of:
 - "Procedure, Performed: Colonoscopy" <= 9 year(s) ends before end of "Measurement Period"
 - "Laboratory Test, Performed: Fecal Occult Blood Test (FOBT) (result)" during "Measurement Period"
 - "Procedure, Performed: Flexible Sigmoidoscopy" <= 4 year(s) ends before end of "Measurement Period"

Case Study 2: MediCal Waiver Pay for Performance Metrics

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Our Solutions:

(2) Registry and DataLink Action for External Data



Our Solutions

(3) Gap Score within Provider Schedules

	Time	Checked In	Age/Sex	Pref Langu	PRIM	Compl	Status	Type	PCP	CE	Coverage	Pt. Port
●	1:00 PM	12:31 PM	61 y.o. / F	Spanish	0	3	Closed:...	FOLLOW-UP	CERVENKA, AN...	●	VALLEY HEALT...	Active
●	1:15 PM	1:10 PM	27 y.o. / M	English	1	3	Closed:...	SAME DAY	JAYAKAR, SAR...	●	VALLEY HEALT...	Active
●	1:30 PM	12:46 PM	53 y.o. / F	English	0	2	Closed:...	SAME DAY	CERVENKA, AN...	●	MEDICARE	Active
●	1:45 PM	1:53 PM	56 y.o. / F	English	3	4	Closed:...	NEW PATIENT	YARLAGADDA,...	●	VALLEY HEALT...	Pend...
	2:15 PM		52 y.o. / M	English	2	6	No Sho...	FOLLOW-UP			VALLEY HEALT...	Cod...
●	2:30 PM	2:01 PM	62 y.o. / F	Spanish	0	3	Closed:...	FOLLOW-UP	CERVENKA, AN...	●	VALLEY HEALT...	Pend...
●	2:45 PM	2:35 PM	67 y.o. / M	English	1	1	Closed:...	FOLLOW-UP	CERVENKA, AN...	●	MEDICARE	Active
●	3:15 PM	3:06 PM	42 y.o. / F	English	0	3	Closed:...	FOLLOW-UP	CERVENKA, AN...	●	BLUE CROSS M...	Active
●	3:30 PM	3:24 PM	43 y.o. / M	English	0	0	Closed:...	FOLLOW-UP	CERVENKA, AN...	●	VALLEY HEALT...	Active
●	3:45 PM	3:48 PM	61 y.o. / F	English	1	3	Closed:...	NEW PATIENT	CERVENKA, AN...		VALLEY HEALT...	Active

← | 👤 | 📷 SnapShot | 📄 Rooming Report | 📄 Visit Orders | 📄 Last Outpatient Note | 📄 Transplant Meds/Labs | 📄 After Visit Summary | 📄 Risk Profile

Complexity Score

0 - 4 Points: Low Risk
✓ 4 5 - 8 Points: Medium Risk
9 - 50 Points: High Risk

Change: ⬆

Details

Prime Care Gap Score

0 Points: Low Risk
⚠ 3 1 - 3 Points: Medium Risk
≥ 4 Points: High Risk

Change: ⬇

Details

Points Metrics

This score identifies care gaps for PRIME patients

0 Poorly Controlled Hypertension: 0
1 Overdue Colorectal Cancer Screening: Yes
0 Overdue Influenza Vaccine: No
1 Hemoglobin A1c: Not on file
1 Annual Monitoring: ACE or ARBs - Missing labs: Yes

Our Solutions

(4) Targeted BPAs and BPA Analysis

Dx/Tx

Order Sets | Prep for Surgery | References | Patient Education Materials | Images | History | Quick Questions | MAR | Medications

BestPractice | Visit Diagnoses | Problem List | Allergies

BestPractice Advisories

Last refreshed on 11/16/2016 at 3:08 PM

Ischemic vascular disease and not on antiplatelet therapy. This patient has a diagnosis of IVD and is not on antiplatelet therapy. Open the suggested SmartSet to order antiplatelet therapy or indicate the reason for not prescribing.

Antiplatelet therapy preview

Acknowledge Reason _____

⚠ Patient has a Smokeless Tobacco status of "Unknown". Please document this required field.

[Click Here To Go Directly To The Smokeless Tobacco Documentation](#)

Acknowledge Reason _____

Our Solutions

(5) Screening Tools

Screening Tools

COMMONLY USED TOOLS

AIMS

ASQ Summary

Audit-C

BI POLAR SCORE...

CIWA

DAST

ANXIETY SCALE...

GERIATRIC DEP...

MLP Screen

MORS SCORE

PHQ-9 DEPRESS...

SBIRT Screening...

STAYING HEALT...

SUICIDE ASSES...

Urges to Drink

PHQ-9 DEPRESSION SCALE

+ New Reading

No data found.

Flowsheets

SBIRT Screening Tools

SBIRT Brief Screening

Drugs: Recreational drugs include methamphetamines (speed, crystal) cannabis (marijuana, pot), inhalants (paint thinner, aerosol, glue), tranquilizers (Valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).

How many times in the past year have you had 4 or more drinks in a day?

None1 or more

How many times in the past year have you used a recreational drug or used a prescription medication for nonmedical reasons?

None1 or more

RestoreClose F9

Previous F7Next F8

STAYING HEALTHY ASSESSMENT

Suicide Risk Assessment

+ New Reading

No data found.

Flowsheets

Our Solutions

(6) Health Maintenance

Health Maintenance

Postpone

Remove Postpone

Override

Remove Override

Document Past Immunization

Edit Frequency

Edit Modifiers

!! New data from outside sources are available for reconciliation. Health Maintenance topics may not be up-to-date.

Reconcile outside data on the chart. [Medications](#)

	Due Date	Topic	Frequency	Date Completed		
⬇	12/17/1980	Mammogram/ Screening	2 year(s)			
⬇	11/1/2009	Pap Smear	3 year(s)	11/1/2006		
⬇	12/17/2010	Colon cancer screening annual FIT/FOBT	1 year(s)			
⬇	7/15/2014	Retinal Screening	1 year(s)	7/15/2013 (Done)		
⬇	7/31/2014	Hemoglobin A1C	1 year(s)	7/31/2013	6/6/2013	6/26/2012
	9/1/2017	Influenza Vaccine	8 month(s)			
	5/31/2018	Annual Diabetes Foot Exam	1 year(s)	5/31/2017		

Our Solutions

(7) Order Sets for High Cost Medications

ORDERS FOR HOSP/PROCEDURES

Review Orders

Order Sets

Orders

Order Sets

✔ Multiple Versions of User Order Sets [Do Not Show This Again](#)

You can now save multiple versions of user order sets. Click the Manage My Version link below to begin. [Learn More](#)

▼ Hepatitis C - Initial Treatment Smart Set Manage My Version▼

Progress Note [Collapse](#)

> Web link for APRI fibrosis score [Click for more](#)

> Link for HCV treatment guidelines [Click for more](#)

General Orders [Collapse](#)

> Pre-treatment labs. If you add order from this section, defer placing regimen lab orders [Click for more](#)

▼ General meds

☐ acetaminophen (TYLENOL) 500 MG tablet
Normal, Disp-100 tablet, R-2, 500-1,000 mg, Every 8 hours PRN

☐ ondansetron (ZOFTRAN) 4 MG tablet
Normal, Disp-60 tablet, R-2, 4 mg, Every 8 hours PRN

1. ZEPATIER for 12 weeks [Collapse](#)

> Zepatier 12 week med order [Click for more](#)

> Zepatier 12 week labs - start 4 weeks after first dose [Click for more](#)

2. ZEPATIER and RIBAVIRIN for 16 weeks [Collapse](#)

> Zepatier and ribavirin 16 week med orders [Click for more](#)

> Zepatier and ribavirin 16 week labs - start 2 weeks after first dose [Click for more](#)

3. EPCLUSA for 12 weeks [Collapse](#)

> Epclusa 12 week med order [Click for more](#)

Case Study 2: MediCal Waiver Pay for Performance Metrics

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Our Solutions

(8) Refill Protocols

Requested Medications

Rx hydroCHLORothiazide (HYDRODIURIL) 25 MG tablet
Take 1 tablet by mouth daily.

✓ Disp: 90 tablet Refills: 1
Class: Normal Start: 1/10/2017
For: Essential hypertension
Originally ordered: 4 years ago by NEED, INFO
Last refill: 10/17/2016
To pharmacy: D Vu PharmD for Andrea Cervenka, MD
on 7/20/2016

Diuretics Protocol Failed 1/10 5:58 PM 

- ✗ Normal CREAT
- ✗ Normal K
- ✗ Normal Na
- ✓ BP in last 12 months
- ✓ Not pregnant
- ✓ Recent or future visit with authorizing provider

[Protocol Details](#)

To be filled at: MAIL - VHC EAST VALLEY
PHARMACY
Phone: 408-977-3500

Our Solutions

(9) Bulk Ordering and Communication from RWB Reports

Send Staff Message Bulk Orders Send Bulk Communication			
core	Pt Comm Pref	PCP	Monitoring: ACD al Monitoring: Di
MyChart	Andrea	Yes	
	Cervenka, MD		
Andrea		Yes	

1. Mail (15 patients)2. Phone (0 patients)3. MyHealth Online (10 patients)

Subject:

Template:PRIME - OVERDUE LAB FOR MONITORING

Copy Mail Template

Reply Options

Allow reply directly to me

abc

Insert SmartText

Allow all current proxies to view this message

Dear @FNAME@,

Your health is important to us. Your doctor recommends regular tests to help monitor and manage your medications.

Our records show that you are due for the following tests marked with an X below:

Lab Tests

Panel 7 , Non-Fasting

Digoxin

These labs are recommended for chronic medication(s) you are taking. You can complete the laboratory test at any Valley Health Center laboratory at your earliest convenience.

Sincerely,

@MEMD@

Santa Clara Valley Health and Hospital System
751 South Bascom Avenue, San Jose, CA 95128

Patient Outreach Tracking

Contacted about:PRIME Pharmacist

Next contact:

1 Month3 Months6 Months1 Year

Accept

Cancel

Our Solutions

(10) Outreach Encounters with Smart Data Elements for Exclusions

6/5/2017 visit with Andrea Cervenka, MD for Patient Outreach

Triage Call Family Switch Questionnaires References Open Orders Dosage Table Appts Care Teams


PATIENT OUTREACH ENCOUNTER
Contacts
Reason for Call
Pt Outreach
PRIME Exclusions
BestPractice
SmartSets
Problem List
Verify Rx Benefits
Medication History
Meds & Orders
Specimen Collection
Gen Care Smartfo...
Documentation
Routing
Sign Encounter

PRIME Exclusions - Reasons for Exclusion

Time taken: 1751 6/5/2017

Values By Create Note

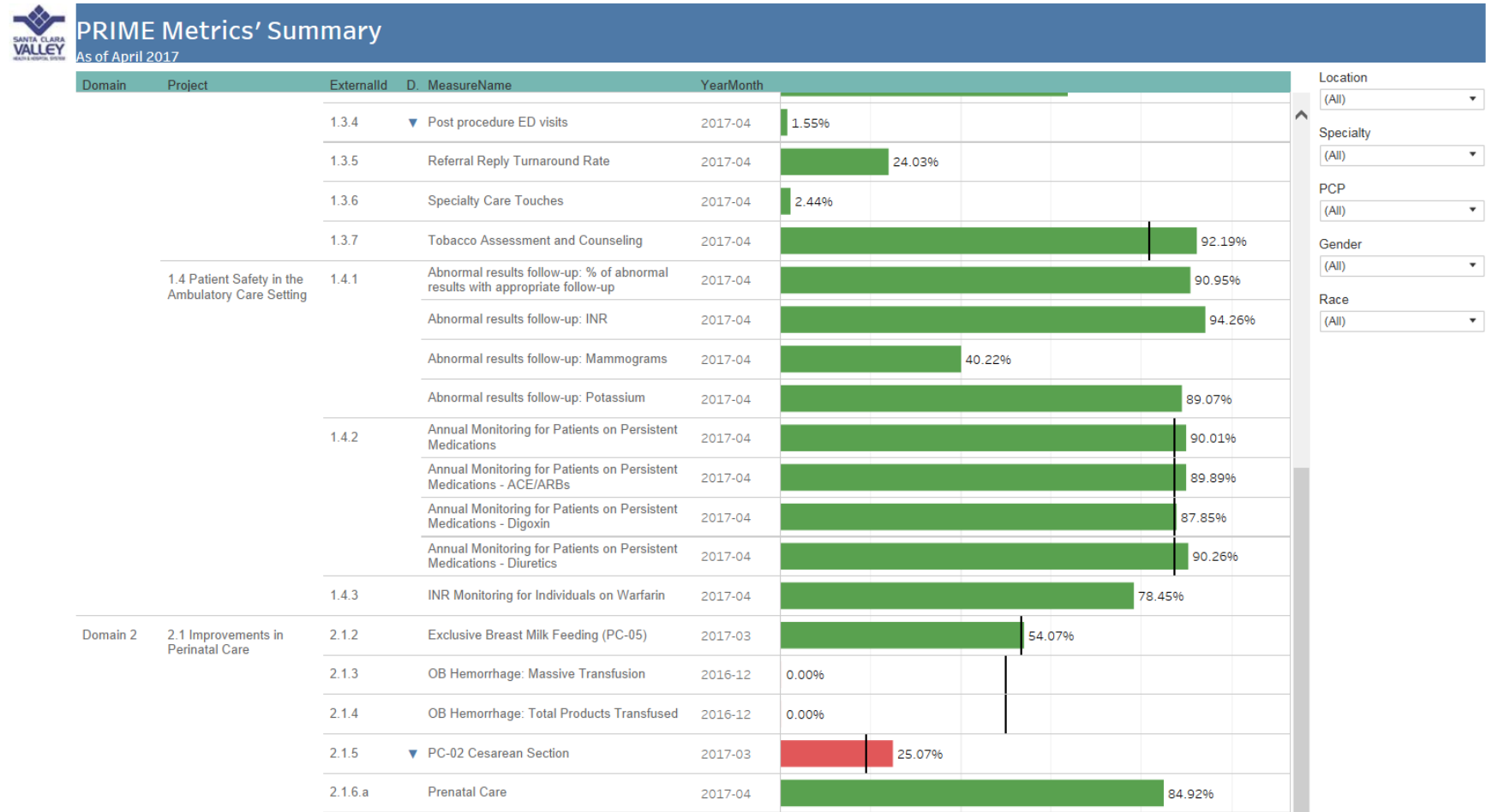
▼ The following patient reported information can exclude patients from PRIME metrics. Any user can document these exclusions.

Patient reportedly now in Palliative Care or Home Hospice	<input type="checkbox"/> Yes <input type="checkbox"/> No
Patient reportedly now long term nursing care resident	<input type="checkbox"/> Yes <input type="checkbox"/> No
Patient reportedly established primary care outside of VMC clinics	<input type="checkbox"/> Yes <input type="checkbox"/> No
Patient reportedly incarcerated for more than 45 days	<input type="checkbox"/> Yes <input type="checkbox"/> No
 Patient now deceased. HIM will be notified.	<input type="checkbox"/> Yes <input type="checkbox"/> No

Restore Close F9 Cancel

Our Solutions

(11) Broad Access via Tableau Dashboard



The Outcome

SCVMC achieved 56 out of 58 Pay for Performance metrics resulting in MediCal revenue of \$53M (FY17)

<Physician leaders and physician builders had direct involvement in tool configuration and implementation>

How Efficiently Are Our Providers Using HealthLink?

Epic Reporting Workbench

Epic Radar

Epic Provider Efficiency Profiles

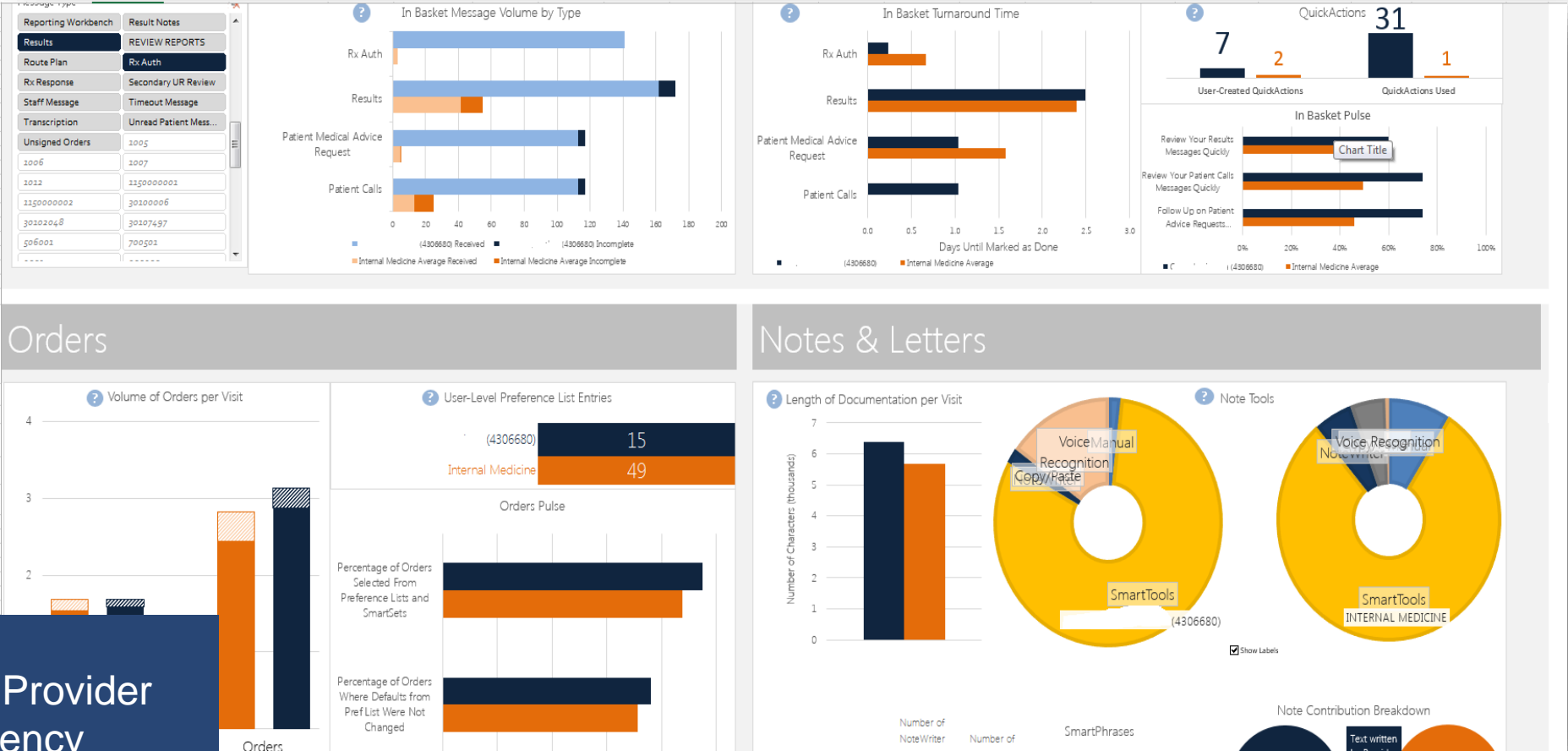
Epic Slicer Dicer

SAP Business Objects Crystal Reports

SAP Business Objects WebI (Universes)

Tableau

Epic Provider Efficiency Profiles



HealthLink Provider Optimization Program

HAPPI –

- Helping
- Achieve
- Provider
- Proficiency
- Intelligently

Goals:

- Reduce redundancies
- Streamline workflow
- Improve Efficiency
- Reduce Off-hour EMR usage
- Improve Physician Satisfaction
- Better Utilize Epic Features
- Enhance the current build where needed

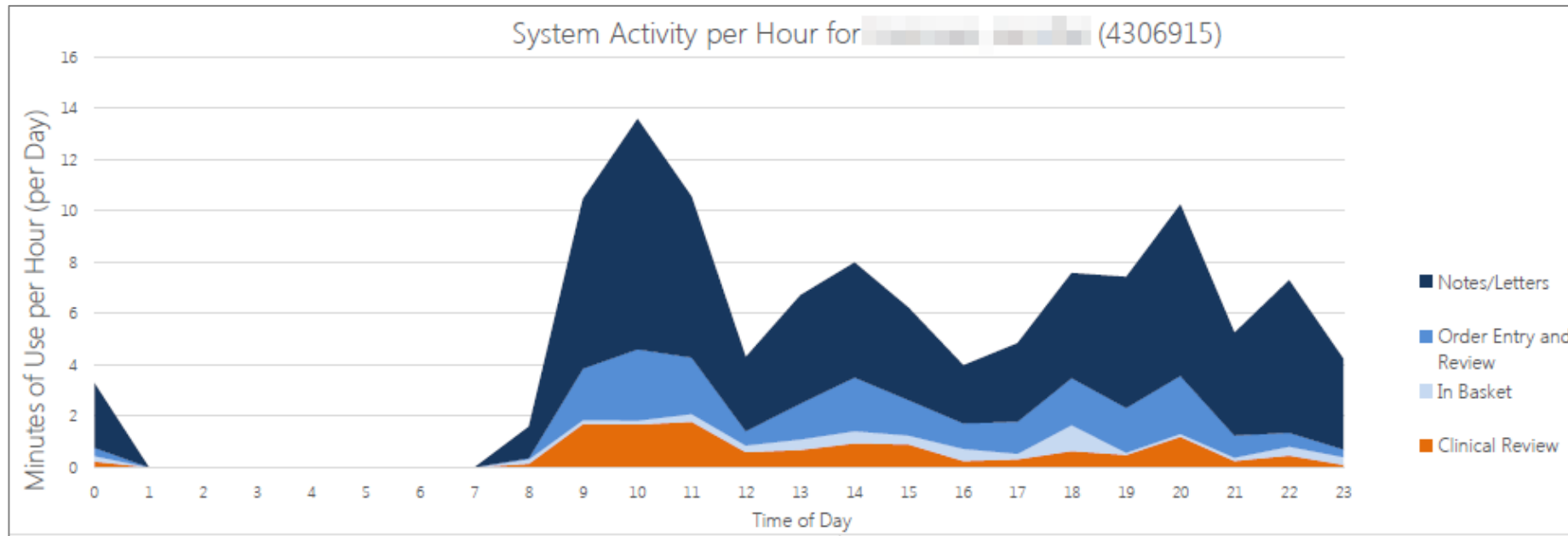
Our Commitment

- Through collaboration and understanding your operations & workflows, we optimize the HealthLink user experience
- Through observation, PEP, and needs assessment, we develop a learning plan
- Learning plan will improve provider efficiency



Optimization Precursors

- Provider Needs Assessment (Survey)
- In person Observation
- Monthly Epic PEP (Provider Efficiency Profile)



Optimization Execution

Individualized Learning Plans

- 1:1 Session

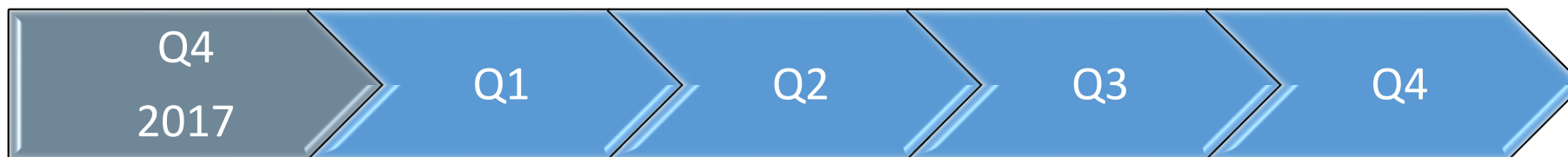
Group Learning Plans

- Small classroom training
- QuickWins sessions at Dept. Mtgs

Others Optional Training

- Personalization Labs
- Dragon Medical One training

Optimization Schedule 2018



- Pediatrics

- Pediatrics
- Peds Specialties
- Internal Medicine
- PM&R

- Internal Medicine
- Family Medicine
- Medical Specialties

- Surgical Specialties
- OB/Gyn

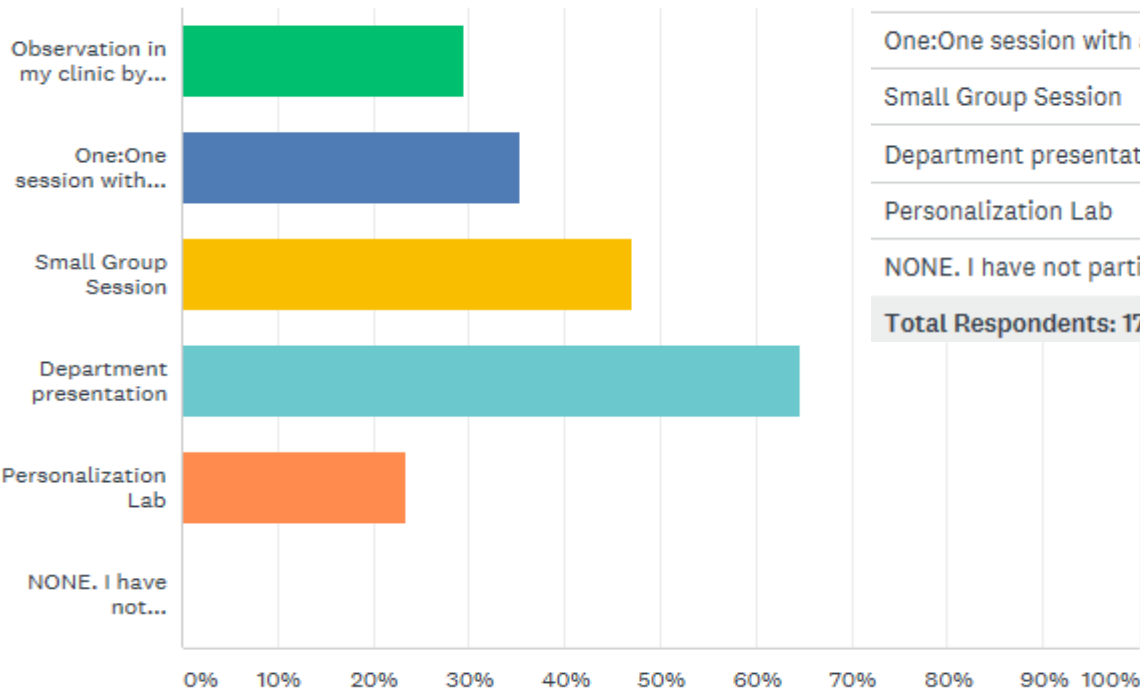
Epic 2018
Upgrade

HAPPI Participation

Q16

Select all of the types of Optimization Sessions (2017-2018) that you participated in (not including help from departmental super-user).

Answered: 17 Skipped: 0



ANSWER CHOICES	RESPONSES	
Observation in my clinic by an Optimization Specialist	29.41%	5
One:One session with an Optimization Specialist	35.29%	6
Small Group Session	47.06%	8
Department presentation	64.71%	11
Personalization Lab	23.53%	4
NONE. I have not participated in any Optimization Session(s).	0.00%	0
Total Respondents: 17		

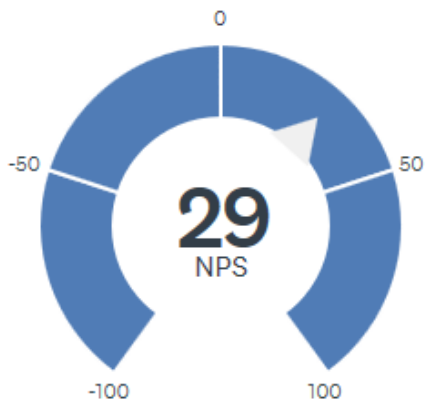
Most participants
at 2 or more
venues

The HAPPI Program: Net Promoter Score

Q18

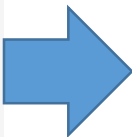
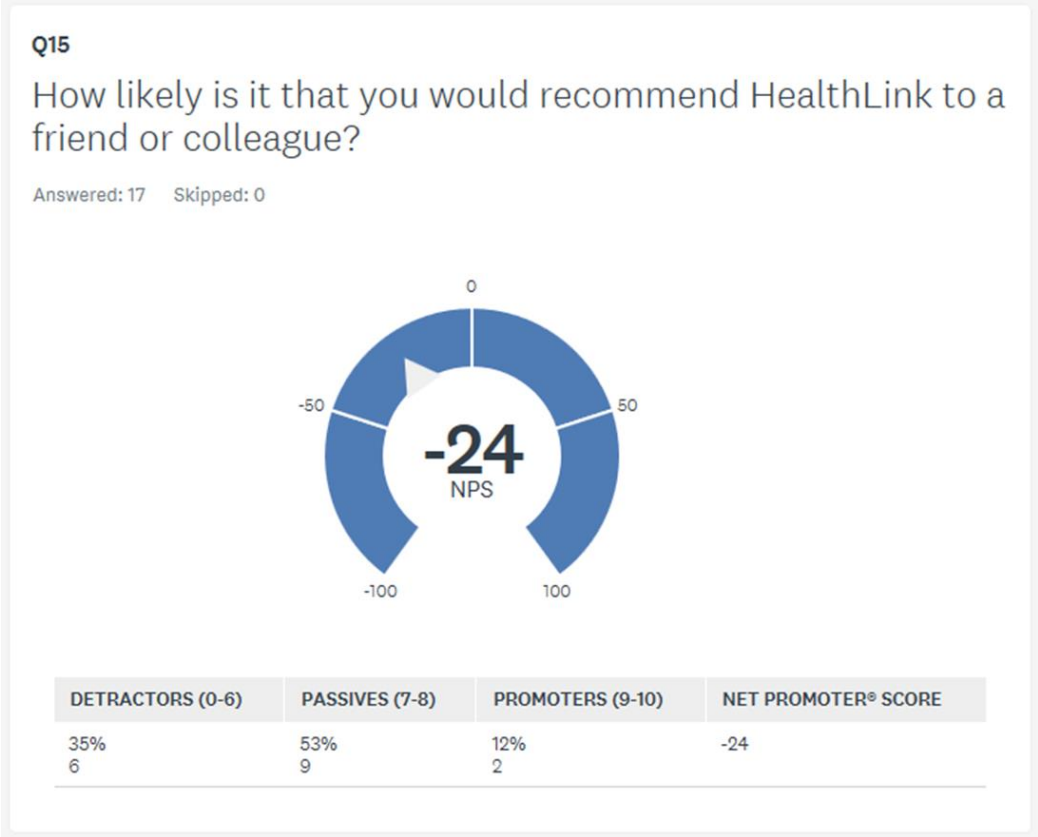
How likely is it that you would recommend the Provider Optimization Program (HAPPI) to a friend or colleague?

Answered: 17 Skipped: 0



DETRACTORS (0-6)	PASSIVES (7-8)	PROMOTERS (9-10)	NET PROMOTER® SCORE
29% 5	12% 2	59% 10	29

HAPPI: Moving the Dial for HealthLink NPS



New Opportunities for Physician Leaders: Two new hospitals(!)

For providers:

- “Non-employed” physicians at OCH/SLRH and DePaul
- Differences in how organizations treat providers
 - E.g. “Provider Resource Group (PRG) for dedicated 24x7 IT support
- IT infrastructures/EHRs badly in need of an upgrade
 - OCH is on Quadramed; SLRH is on Paper
 - Recent (last 2 years of) work on an Allscripts inpatient implementation
- Existing/distinct “MSITs” at OCH/SLRH (and SCMVC)
 - But one license -> one medical staff, and one integrated MEC; can delegate to local committees
- Planning Epic implementations at all three new locations
 - But NOT (yet) at individual provider offices outside of SCVMC

New Opportunities for Physician Leaders: Developments from T2020

- **All Things Diabetes:** Dr. Patty Salmon, Sonia Menzies
 - “doing the right thing for people with -- or at risk of developing -- diabetes”
- **All Things Substance Use:** Drs. Jack Westfall/Brent Miller and Nari Singh
 - “doing the right thing for people with -- or at risk of harm from -- substance use disorder”
- **All Things Health Homes:** Dr. JP Pham, Serena Sy, Jake Johnson, others TBD
 - “doing the right thing for people in -- or at risk of entering -- high-utilizer groups”
- Each featuring Clinical & Operational Leadership, HL and Analytics participation, Project Management
- Each featuring new tools from Epic which need configuration, validation and coordination(!)

Implications for SCVMC/HHS

- It's VERY busy now
- We need all hands on deck to help us with new Epic implementations
 - This starts pre-golive w **required** training AND personalization labs
 - We'll need 24x7 "elbow" support for providers for 4 weeks during golive
 - The aggressive build timeline for OCH/SLRH means MUCH will be left for "optimization"
- Meanwhile, we need to **backfill** to keep existing high-priority projects going
- Encourage and support your colleagues as they dive in and "Get HAPPI" or go further ...
 - MDs who do their own personalization, become MD powerusers, become MD builders
 - Maybe even pursue board certification in clinical informatics (there are 8 of us now)
- Important to monitor burnout, perhaps see improvement

Our Message for Physician Leaders

- Participate/Encourage Participation in MSIT
- Get HAPPI yourself; encourage your colleagues to get HAPPI
- Help promote our HAPPI surveys: see if all of this is helping with burnout
- Become a HealthLink PowerUser – Yes, you(!); help with “elbow” support during golives
- Help Recruit/Support Physician Builders/Analysts
- Support In-Depth Physician (& Provider) Administrative Activity with the CMIO on IT Projects
- Help us promote “Data Literacy” among providers; Learn/Take Advantage of SlicerDicer
- Help Us Prioritize/Roll Out Epic Foundation/Custom Predictive Models
- Work with Us to Identify/Solicit Comparative Effectiveness Projects Locally and Regionally



**SANTA CLARA
VALLEY MEDICAL CENTER**
Hospital & Clinics

**Questions/
Comments?**

County of Santa Clara