2015 Acclaim Award
Breaking (Not Bending) the Cost Curve to Achieve the IHI Triple Aim
New West Physicians

October 2015
Ken Cohen, MD, FACP, CMO
What defines a high performing organization in 2015 and beyond?

- Organizational Culture
- Brand Identity
- Pursuit of evidenced based medicine
- Patient Engagement
- Provider Satisfaction
- Shared Decision Making
- Strong supported primary care base
- Good Data
- Care across the continuum
- Accountability for quality, service, and cost
If you take one point home.....

- There is no relationship between cost of care and quality of care

- More care does not equal better care
Solution to Care Efficiency

• Elimination of wasted care!!

• Wasted care is care that does not improve health outcomes or quality of life

• Estimated at 35% of all HC expenditures
Wasted Care Examples

• Cardiology - Nuclear stress testing in asymptomatic CAD
• Oncology – futile care for advanced cancers
• Pulmonary – low risk lung cancer screening
• Orthopedics - Viscosupplementation
• Dermatology – Mohs for small basal cell cancers
Bench to Bedside

• Bench to bedside is the rapid transition of high quality EBM into daily clinical practice

• Typical delay in adoption of EBM – 5 years
Slow Adoption of EBM

- Information overload – over 100,000 pages of new science monthly
- Clinical inertia - the phenomenon of providers maintaining stable and comfortable practice patterns in the face of literature suggesting the need for change
- Financial conflict
  - EBM that supports revenue tends to be more quickly adopted
  - EBM that threatens revenue often dismissed as methodologically flawed
Implementation – Bench to Bedside

• Monthly review of evidenced based literature for rapid transition to practice
• Conflicts with current practice patterns resolved by consensus
• Clinical algorithms built and implemented
• Algorithms supported by referral department
• Lack of adherence places referral stream at risk
Bench to Bedside in Practice

• Prostate cancer – Gleason 6 active surveillance
  – National rate <50%, post Bench to Bedside – 84%
• Barrett’s Esophagus Surveillance
  – National – 1-3 years, post Bench to Bedside – 5 years
• Vertebroplasty/Kyphoplasty
  – Use fell by >90% within 3 months of EBM publications
• Intracranial stenting for TIA/stroke
  – Moratorium for interventions outside of clinical trials
Population Health Management

- Primary Care
- Specialty care
- ER and Urgent care
- Hospital care
- Post hospital care transition
- SNF care
- Palliative and end of life care
Primary Care

• Comprehensive registry at the point of care
  – Evidenced based guidelines
  – Gaps in care

• Individual utilization by specialty, hospital, pharmacy

• Un-blinded comparative reporting

• Compensation model that rewards both quality and efficiency
Specialty Care

• Dedicated narrow specialty network

• Signed “pact” by all specialists for maximal adherence to quality/utilization guidelines

• Collaborative (usually) meetings with major specialty groups – oncology, cardiology, orthopedics, surgery
Hospital Program

• NWP Hospitalists at our 5 main hospitals
  – Evaluations take place in the ER
• NWP Case management daily at all facilities
• At every admission:
  – Psychosocial evaluation
  – Home safety evaluation
  – Evaluation of any outpatient PCP deficiencies
  – Advanced directives
Post Hospital Discharge Program

- Medication reconciliation performed and populated into the EHR
- Problem list updated including new RAF codes
- Specialist and ancillary visits coordinated
- All hospital records uploaded into EHR
- Direct messaging to PCP in advance of office f/u with key issues communicated
- Medicare readmission rate – 6.7%
Advanced Care Planning

- Transitional care program – designed for intensive home based 6 month case management for advanced and/or complex illness
- Palliative care program – mandatory for oncologists to introduce palliative care for all Stage III and IV cancers
- Hospice care program integrated with the above two programs
Diabetes Care as an Example of Population Health Management

• Lifestyle education to prevent diabetes
  – The Nutrition Source
  – Tracking BMI and exercise at every visit
  – Pre-diabetes classes
  – Intensive diabetes prevention course

• Primary care office – MA working at top of license
  – Completion of diabetes flow sheet
  – Ordering labs and education referrals as indicated
  – Performing immunizations and foot examinations
  – Medication adherence
Diabetes care – cont.

• Diabetes and Nutrition Center
  – Individual and class education for wide range of disorders
  – All new insulin starts and pump patients
  – Reflex referrals if HbA1c > 8.5%

• ACO
  – Health plan databases searched to identify gaps in care – patients contacted and red flags placed
  – Quality of care tracked to the individual PCP level
  – Pharmacoeconomic education to providers

• Hospitalists – the Lexus concept
Patient Centric Care
Who Will Succeed?

• Shift from patient to population management
• Elimination of wasted care
• Provision of actionable data
• Comprehensive care at all levels and locations
• Focused case management
• Aligned compensation model
Thank you and Opportunity for Questions

The mission of New West Physicians is "to enhance the physical, mental and spiritual health of communities we serve through an integrated, primary-care owned and patient centered healthcare delivery system."
Cornerstone Health Care: 2015 Acclaim Award Recipient

Grace Terrell, MD, MMM
Cornerstone Health Care, PA
President/CEO
CHESS
President/CEO
Our journey began...
We decided to make the move toward a value driven health care system in 2010.
Mission:
To be your medical home

Vision:
To be the model for physician-led health care in America

Values:
As a physician owned and directed company, we are committed to ensuring that patient care is efficient, effective, equitable, patient centered, safe, and timely
Our Goals

1. Reduce Fragmentation
2. Reduce unexplained variation of care
3. Optimize patient engagement
4. Use evidence based care
5. Apply resources to the most appropriate level
6. Improve satisfaction for patient & provider
Steps taken to becoming a high performing health system

- Redesigned Governance Structure
- Developed Care Models
- Established Smart Care Teams
- Partnered Together
- Drove Utilization
- Quantified Impact
- Learned from the Process
We redesigned our governance structure to include committees that focused on our new goals.
We developed disease specific care models that were evidence based.

- Chronic Heart Failure Model
- Care Outreach Model
- Personalized Primary Care Model
- Extensivist Model
- Oncology Model
- COPD Model
- Nephrology Medical Home Model
Smart Care Teams intervened with our most vulnerable patients

- Patient Care Advocates
- Health Navigators
- Patient Engagement Coordinators
- Encounter Specialists
- Referral Advocates
- Transitions of Care Navigators
- Extensivists & Hospitalists
Working partnerships were vital to effectively manage our patient population.
Clinical information resources allowed us to analyze patient care, quality, cost and outcome data, and to measure our progress through this transformation.
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Unnecessary costs were prevented or reduced based upon eliminating unexplained variation in care and identifying lower cost settings for care when appropriate.
Implementation of care models helped achieve some of the cost savings anticipated in this transformation.

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<tr>
<th>Select Programs</th>
<th>Per Patient (Savings) or Increase</th>
<th>Total Extrapolated (Savings) or Increase</th>
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<td>($4,076)</td>
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Savings Rate of 3.65%
Cornerstone began with a quality score of 51%
Cornerstone ACO has the highest quality scores of North Carolina ACOs.

Of 214 ACOs nationally, Cornerstone ACO was ranked 6th.
“Between the idea and the reality falls the shadow”

T.S. Eliot
The secret of getting ahead is getting started. The secret of getting started is breaking your complex overwhelming tasks into small manageable tasks, and then starting on the first one.

- Mark Twain