Culture Change:
On-Ramp to Population Health
Scott Foster, MD
System Medical Director
PeaceHealth Medical Group
Specialty Care

Robin Virgin, MD
System Medical Director
PeaceHealth Medical Group
Primary Care
Founded by the Sisters of St. Joseph of Peace
~120 Year Heritage in the North-West

Collaboration  |  Respect  |  Social Justice  |  Stewardship
PeaceHealth Medical Group

- Serving the Pacific Northwest since 1890
- Over 800 employed providers
- Primary care, medical & surgical practices
- Over 40 specialties & subspecialties
- Operating 63 clinic sites
- 10 Medical Centers (5 Critical Access)
- Serving over 350,000 patients
DO THESE SLIDES LOOK FAMILIAR?
Consistent, coordinated care across the continuum
PCT Roadmap

Basic
- Standard Office Flow
- Increase efficiency
- Begin monitoring clinic level data

Intermediate
- Introduce new roles
- Optimize core components
- Team-based care emphasis
- Introduce new roles
- Caregivers engaged in PI
- Practice Coach help
- Move to Preventative focus

Advanced
- Patients have access to care at convenient times, locations and venues
- Innovative practice and technology application
- Improve the health of the population
- Effective, high-functioning practice

Foundational: Payer Strategy, CareConnect Enterprise, Care Optimization, Provider Comp
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<thead>
<tr>
<th>Basic</th>
<th>Intermediate</th>
<th>Advanced</th>
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<tbody>
<tr>
<td>• Integration of evidence based protocols</td>
<td>• All Basic +</td>
<td>• All Basic + Intermediate +</td>
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<tr>
<td>• Define system standard work and workflows</td>
<td>• Team Based Care</td>
<td>• Pay for performance compensation measures</td>
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<td>• Pre-visit preparation</td>
<td>• LPNs as care coordinators</td>
<td>• Co-location of community services</td>
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<td>• Check In/Check Out</td>
<td>• Social work incorporated into team</td>
<td>• Price transparency pilot</td>
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<td>• RPI work, Med Rec and InBasket Management</td>
<td>• Clinic ownership in process improvement</td>
<td>• Established fee structure for employees</td>
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<td>• Transitions of care for recently hospitalized</td>
<td>• Registry driven risk stratification and outreach</td>
<td>• Integration of behavioral analytics</td>
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<td>• Registry driven chronic disease management</td>
<td>• Care continuum partnerships with acute care</td>
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<td></td>
<td>• Complex Case Management (target top utilizers &amp; populations which we have financial risk)</td>
<td>• Hospice/Palliative Care</td>
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<td>• Integration of patient navigators</td>
<td>• Group visits</td>
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<td>• Patients engagement in process design</td>
<td>• Self-rooming</td>
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<td>• Redesign of physical space to support model</td>
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<td>• Leveraging technology, virtual care, monitoring &amp; predictive modeling tools.</td>
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<td>• Patient self-engagement program offerings</td>
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<td>• Activation monitoring and health coaching</td>
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<td>• Onsite service availability (nutrition, pharmacy, dental)</td>
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<td>• All in One model of care expansion</td>
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PHMG System Wide Diabetes Bundle
December 2014-October 2015

Percentage

Month

Vancouver
Longview
Eugene/Springfield
Florence
Cottage Grove
Whatcom
Ketchikan
Target
WHAT HAPPENED?
Timeline of our Journey

- **July 2014**: DMS rollout
- **Aug-Oct 2014**: Primary Care begins
- **Dec 2014**: Network and community Leadership Groups assume ownership and oversight of work
- **Jan 2015**: Med Rec
- **Feb 2015**: RPI
- **Mar 2015**: Network and community Leadership Groups assume ownership and oversight of work
- **Apr 2015**: Core Leadership Team Created
- **May 2015**: CCM Training & Rollout
- **July 2015**: Medical home for all PC
- **Jan – July 2016**: Transition to Primary Care Transformation

Where we are today:
- Aligning work with CMS Grant
- Optimal staffing ratios defined
- Refreshing TCM work and Panel Management
- Network roadmaps for standard workflows in process for all PC

- **July 2014**: PCMH Practice Coaches Hired
- **Aug-Oct 2014**: Testing and workflow optimization
- **Dec 2014**: New governance structure
- **Jan 2015**: Transition to Primary Care Transformation
- **Feb 2015**: Core Leadership Team Created
- **Mar 2015**: Network and community Leadership Groups assume ownership and oversight of work
- **Apr 2015**: CCM Training & Rollout
- **May 2015**: Medical home for all PC
- **July 2015**: PCMH Clinical Positions Posted (60% hired to date)
- **Jan – July 2016**: Future state workflow design: r/t Care Coordination
- **Jan – July 2016**: Thorough evaluation of work to date and re-engagement of teams
CULTURE CHANGE

• Medical Home on its own is a massive undertaking
• Medical Neighborhood is even bigger
• Most of the tactics are internally focused on operational optimization, roles

………but population health is as much about, if not more about the patients who aren’t even there!
CULTURE CHANGE

- Change requires careful and consistent communication about expectations
  - All day, every day is best

- Change requires a focus on simplicity
  - One step at a time

- Change requires transitional time and resources
  - Put your money where your mouth is

- Change requires leadership and accountability
  - Follow-through is everything. Trust, verify and correct!
AN IMPORTANT LESSON
CMS INNOVATION GRANT ’12 -‘15

• Awarded to “triple aim projects targeting those enrolled in Medicare, Medicaid and the CHIP, particularly those with the highest health care needs”

• 3,000 applications, 107 grants were awarded.

• PH Ketchikan only grant awarded in Alaska.

• $3.1 M
PROGRAM GOALS

1. Improve access

2. Increase support for targeted populations
   (chronic disease management & health maintenance)

3. Establish a formalized Medical Assistant (MA) training program:
   – Internal: competency curriculum and training process for all existing and newly hired MA’s
   – Work with educational partners to establish a certified MA training program for SE Alaska
CLINICAL AREAS OF FOCUS

• Patient identification, risk stratification and targeted outreach to improve:
  – Diabetes Management (BP, Cholesterol, and A1C)
  – Chronic Heart Failure (readmission and 7-day f/u)
  – Childhood and adult immunizations
  – High risk pregnancies
  – Mammography Screening
  – Colorectal Screening
  – Blood Pressure Management
  – Cholesterol Management
  – Smoking Cessation
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THE SECRET SAUCE

• The Team
  RN, SW and PAR/MA

• Leadership
  Program Manager + Amb Services Director

• Transparency
  Data Reports
WHAT THINGS WORKED?

• Review the 102 Reports & Clinic Schedule
  – Call *Every Patient* starting with high risk 1st.

• Disease and Wellness Management through Outreach.
  – Use of disease registries
  – Follow up to ensure adherence to care plan.
  – Pull patients in for preventive activities.

• *Selective* patient referrals from physicians to care team.


• TCM Visits

• Depression screening

• Med Rec and Optimization
Transitional Care
- Discharge Patient f/u from hospital
- 102 Calls within 2 business days
- Follow-up visits facilitated

Out of Clinic
- Chronic Disease Management
  - Pt Contact Every 10 weeks
  - DM Phone Calls
  - HTN Phone Calls
  - Living Well AK Health maintenance

Clinic Based
- > 3 Encounters
- Referrals From Providers
- Self Referrals from outreach/hot spotting
- Functional CM Panel

Patient Navigation/Support
- < 3 encounters
- Hot spotting
- Home monitoring
- Overcoming hurdles
- PT Education
- Provider Referrals
- Self/outreach referrals
THE 102 REPORT

• A predictive model of 30 day readmission risk.
• Credit to WAHA (Whatcom Alliance for Health Advancement).
• Validated tool that uses 14 variables to predict readmission risk.
• Triggering event is: hospital admission, ED visit or Immediate Care visit
• Produces High (8%), Medium (20%) and Low risk (72%) categories.
<table>
<thead>
<tr>
<th>Variable Name</th>
<th>Variable Description</th>
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<tbody>
<tr>
<td>Age*</td>
<td>Age</td>
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<td>Minority</td>
<td>Minority</td>
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<tr>
<td>Bridge</td>
<td>Received Bridge Assistance within past 365 days</td>
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<td>AdmitED</td>
<td>Admitted from ED</td>
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<tr>
<td>InpatientYear</td>
<td>Two or more inpatient visits in past 365 days</td>
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<tr>
<td>InpatientMonth</td>
<td>One or more inpatient visits in past 30 days</td>
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<tr>
<td>LongLOS</td>
<td>One or more visits with a length of stay of 3 or more days in past 180 days</td>
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<tr>
<td>CharlesonIndex*</td>
<td>Charleson Index (predictor of ten year mortality rate based on several comorbid conditions)</td>
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<td>Polypharmacy</td>
<td>Five or more active meds</td>
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<td>ESRD</td>
<td>End stage renal disease</td>
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<tr>
<td>COPD</td>
<td>Chronic obstructive pulmonary disease</td>
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<tr>
<td>Diabetes</td>
<td>Diabetes</td>
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<tr>
<td>MentalHealth</td>
<td>At least one of: dementia, bipolar, schizophrenia, other mental health (unknown)</td>
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<tr>
<td>PPMentalHealth</td>
<td>Interaction between Polypharmacy &amp; MentalHealth</td>
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* Age and Charleson Index were included in the models as continuous whereas all other variables were included in binary form.
## Table 1. Charlson Comorbidity Index Scoring System

<table>
<thead>
<tr>
<th>Score</th>
<th>Condition</th>
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| 1     | Myocardial infarction (history, not ECG changes only)  
        Congestive heart failure  
        Peripheral vascular disease (includes aortic aneurysm ≥6 cm)  
        Cerebrovascular disease: CVA with mild or no residua or TIA  
        Dementia  
        Chronic pulmonary disease  
        Connective tissue disease  
        Peptic ulcer disease  
        Mild liver disease (without portal hypertension, includes chronic hepatitis)  
        Diabetes without end-organ damage (excludes diet-controlled alone) |
| 2     | Hemiplegia  
        Moderate or severe renal disease  
        Diabetes with end-organ damage (retinopathy, neuropathy, nephropathy, or brittle diabetes)  
        Tumor without metastases (exclude if >5 y from diagnosis)  
        Leukemia (acute or chronic)  
        Lymphoma |
| 3     | Moderate or severe liver disease |
| 6     | Metastatic solid tumor  
        AIDS (not just HIV positive) |

**NOTE.** For each decade > 40 years of age, a score of 1 is added to the above score.

**Abbreviations:** ECG, electrocardiogram; CVA, cerebrovascular accident; TIA, transient ischemic attack; AIDS, acquired immunodeficiency syndrome; HIV, human immunodeficiency virus.
Care Management Recently Discharged Patients (102) - SOUTHWEST

Inclusions: Patients who have had an Emergency (E), Hospital (I, V) or Urgent Care visit discharged from 2/15/16 - 2/15/16

*Patients with the highest calculated risk score are sorted to the top. (See Appendix A for definition of risk factors)*

Prior ED or Inpatient Visits - Count of ED or Inpatient visits in the previous 12 months (not counting the current visit)

Visit Types: E = Emergency, I = Inpatient, V = Observation, and C = Clinic (C is for Urgent Care in this report except for Whatcom where Urgent Care is excluded)

Patients with one of the following discharge dispositions are included:
- Hospice-Medical (51, 54)
- Hospice-Home (53, 40)
- Home (1, 21)
- Left before being seen (97)
- Left before treatment completed (29)
- Against Medical Advice (7, 27)
- Home Health Care (8)
- SNF (3, 23)
- Short Term Hosp as IP (2)

Exclusions: Patients with an account service of Newborn / Well Baby, Obstetrics / OB Testing / OB Gyn, Neonatal / NICU or Boarder Baby are excluded from the report.

Highlights: Patients with a Heart Failure Diagnosis will have a ♥ before their name. If the patient has a PHQ9 or PAM finding their most recent result and the result date will display

Disclaimer: For areas with more than one PH hospital; for example if a patient was transferred from PHH to SHRB, only their SHRB visit will be counted/listed.

Data Source: Epic Clarity, LastWord, MRCode, and Xtend datamarts.
### Care Management Recently Discharged Patients (102)

**FAMILY MED OF SW WASH**

<table>
<thead>
<tr>
<th>Provider: BAKER, STEVEN E</th>
<th>Minority</th>
<th>Bridge Assist</th>
<th>Admit from ED</th>
<th>Two Inpt (1yr)</th>
<th>One Inpt (30 Days)</th>
<th>Long LOS</th>
<th>Charlson Index</th>
<th>Poly Pharm.</th>
<th>ESRD</th>
<th>COPD</th>
<th>Diabetes</th>
<th>Mental Health</th>
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<tbody>
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<td>1</td>
<td>Name:</td>
<td>MRN:</td>
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<td>Patient Home Phone:</td>
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<td>High Risk Disease/s: COPD/Diabetes/Heart Failure</td>
<td>Facility: Type: V</td>
<td>Admit: 2/14/16</td>
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<td>Disch. Disposition: Home or Self Care</td>
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Notes:

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<tr>
<th>Provider: LONG, JACK E</th>
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<th>One Inpt (30 Days)</th>
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Notes:
### Care Management Recently Discharged Patients (102)

#### Provider: WHEELOCK, CHRISTOPHER B

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**Notes:**

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#### Provider: ROMPALA, KATHRYN

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  – Follow up to ensure adherence to care plan.
  – Pull patients in for preventive activities.
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• Depression screening
• Med Rec and Optimization
PROGRAM OUTCOMES

- 61% reduction in unnecessary ED visits (13 to 5 per month)
- 84% reduction in 30 day readmission rates for CHF (31% to 5%)
- 39% improvement in 7-day f/u for CHF discharges
- 125% improvement in smoking cessation offered (43% to 97%)
- 26% improvement in childhood immunization rates
- 6% reduction in cost per beneficiary encounter
- 78% of patients discharged from E.D. or Hospital received a TCM contact
- Partnered with the University of Alaska to develop a formal Medical Assistance Program in SE Alaska
## Method #1:
**Cost per Beneficiary per Encounter**

<table>
<thead>
<tr>
<th>Payer</th>
<th>FY12</th>
<th>FY13</th>
<th>FY14</th>
<th>FY14 % change from baseline FY12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare/Medicaid</td>
<td>$536/encounter</td>
<td>$457/encounter</td>
<td>$507/encounter</td>
<td>(6%)</td>
</tr>
<tr>
<td>Commercial payers</td>
<td>$730/encounter</td>
<td>$655/encounter</td>
<td>$784/encounter</td>
<td>7%</td>
</tr>
<tr>
<td>All Payers</td>
<td>$630/encounter</td>
<td>$586/encounter</td>
<td>$599/encounter</td>
<td>(5%)</td>
</tr>
</tbody>
</table>

## Method #2
**Overall Payments per Payer**

<table>
<thead>
<tr>
<th>Payer</th>
<th>FY12</th>
<th>FY13</th>
<th>FY14</th>
<th>FY14 % change from baseline FY12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare/Medicaid</td>
<td>$11,020,737</td>
<td>$10,422,101</td>
<td>$10,524,819</td>
<td>(5%)</td>
</tr>
<tr>
<td>All Payers</td>
<td>$29,909,760</td>
<td>$28,395,524</td>
<td>$27,843,400</td>
<td>(7%)</td>
</tr>
</tbody>
</table>
WHAT IS CULTURE CHANGING?

1. For OP clinics, some patients NOT in the room are as important as those who are.

2. Daily, prioritized reports drive the work, not just daily schedules.

3. Results are transparent.

4. The hospital was willing to support revenue reduction for the right reasons.
THE LESSONS

1. Keep it simple.
2. Stay focused.
3. Provide the resources.
4. Make results transparent.
WHAT’S NEXT?
NEW CMS TCPI GRANT

• $8M over 4 years

• Requires us to:
  – Engage 577 Providers across PHMG
  – Improve Health maintenance
  – Improve Chronic disease outcomes
  – Decrease admissions & readmissions
  – Reduce unnecessary testing & over utilization
  – Higher level of care and service to patients
  – Collaborate with CMS and other participant groups
<table>
<thead>
<tr>
<th>Quality Targets</th>
<th>Current Performance</th>
<th>Year 1 Targets</th>
<th>Year 4 Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DM Bundle (A1c &lt;8.0, BP &lt;140/90 + Statin)</strong></td>
<td>50.5%</td>
<td>44%</td>
<td>60%</td>
</tr>
<tr>
<td><strong>Hypertension Control</strong> &lt;140/90 18-59 + DM and &lt;150/90 for age &gt;59</td>
<td>74%</td>
<td>75%</td>
<td>85%</td>
</tr>
<tr>
<td><strong>Post Hospitalization, Depression screening PHQ-9</strong></td>
<td>30%</td>
<td>70%</td>
<td></td>
</tr>
<tr>
<td><strong>Tobacco Cessation Offered</strong></td>
<td>90%</td>
<td>95%</td>
<td></td>
</tr>
<tr>
<td><strong>Total Panel Depression Screening Primary Care- PHQ-2</strong></td>
<td>50%</td>
<td></td>
<td>85%</td>
</tr>
<tr>
<td><strong>Breast Cancer Screening</strong> mammogram ages 50-75 every 2 years</td>
<td>53.5%</td>
<td>10% improvement</td>
<td>20% improvement</td>
</tr>
<tr>
<td><strong>Colon Cancer Screening</strong> – FOBT or Colonoscopy</td>
<td>24.5</td>
<td>10% improvement</td>
<td>20% improvement</td>
</tr>
<tr>
<td><strong>Childhood Immunizations</strong> combo 10 with and without parental refusal**</td>
<td>80%</td>
<td></td>
<td>90%</td>
</tr>
<tr>
<td><strong>Flu Shots Age &gt; 6 months</strong></td>
<td>65%</td>
<td></td>
<td>85%</td>
</tr>
</tbody>
</table>
# Utilization Targets

<table>
<thead>
<tr>
<th>Measures for Decreased Utilization</th>
<th>Year 1</th>
<th>Year 4</th>
<th>Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduction in unnecessary lab work</td>
<td>1%</td>
<td>4%</td>
<td>$1M</td>
</tr>
<tr>
<td>Reduction in unnecessary imaging</td>
<td>1.25%</td>
<td>4.75%</td>
<td>$4.3M</td>
</tr>
<tr>
<td>CHF &amp; COPD Readmissions</td>
<td>3%</td>
<td>8%</td>
<td>$3.5M</td>
</tr>
<tr>
<td>Overall Admissions</td>
<td>1%</td>
<td>2.9%</td>
<td>$8.1M</td>
</tr>
</tbody>
</table>
Concurrent Lean Implementation

**Basic**
- CareOptimization-DMS
  1. Success Metrics
  2. Readiness/ Huddles
  3. Standard work (Initial)
    - Pre-visit prep
    - Check out
    - Med Reconciliation

  **Focus on**
  **Episodic Care**

**Intermediate**
- CareOptimization-DMS
  3. Standard Work (cont’d)
    - Refine core components
    - Introduce new roles
    - Disease Management
  4. Problem Solving
    - Problem Solving Circles
    - Caregiver Generated Ideas

  **Move toward**
  **wellness/prevention-based medicine**

**Advanced**
- CareOptimization-DMS
  5. Schedule/Takt
    - Standardizing Patient Flow processes
    - Patients are cared for when they want, how they want, where they want

  **Improve health of population**;
  **Effective, high-functioning practice**
TRANSPARENCY

- Performance boards live in every clinic.
- Implemented at same time as readiness board.
- Key metrics on display and updated monthly.
- Feed in to readiness boards daily.
- This is our DMS (Daily Management System)
HOW WILL WE DO THIS?

• Review the Reports & Clinic Schedule
  – Call *Every Patient* starting with high risk 1st.

• Disease and Wellness Management through Outreach.
  – Use of disease registries
  – Follow up to ensure adherence to care plan.
  – Pull patients in for preventive activities.

• **Selective** patient referrals from physicians to care team.


• TCM Visits

• Depression screening

• Med Rec and Optimization
## SCOPE DIFFERENCES BY COMMUNITY

<table>
<thead>
<tr>
<th>Community</th>
<th>Provider Count</th>
<th>Empaneled PeaceHealth Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PCP</td>
<td>OB</td>
</tr>
<tr>
<td>Eugene</td>
<td>67</td>
<td>9</td>
</tr>
<tr>
<td>Vancouver</td>
<td>30</td>
<td>11</td>
</tr>
<tr>
<td>Longview</td>
<td>34</td>
<td>9</td>
</tr>
<tr>
<td>Bellingham</td>
<td>47</td>
<td>11</td>
</tr>
<tr>
<td>Alaska</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>Sedro Woolley</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Peace Island</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>
FOUNDATIONAL ELEMENTS

AUTOMATION  - $8M vs $3M
• Key disease registries live with automation.
• 102 report circulated daily per community.
• Outcomes reporting via performance boards.

RESOURCES
• Ability to refocus PHMG clinical leadership time on development and implementation.
• Organizational commitment to reorganize staff around risky populations, not just specific clinics.
• Protection of staff time in key roles.
• Become our PCMH v2.0
## OUR TIMELINE

<table>
<thead>
<tr>
<th>Year</th>
<th>Department</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>All Primary Care, Cardiology</td>
</tr>
<tr>
<td>Year 2</td>
<td>OB/Gyn, ID, Behavioral Health</td>
</tr>
<tr>
<td>Year 3</td>
<td>Pulm, Neuro</td>
</tr>
<tr>
<td>Year 4</td>
<td>GI</td>
</tr>
<tr>
<td>Total</td>
<td>577 providers</td>
</tr>
</tbody>
</table>

Started 10/1/15
GOVERNANCE

MGLT

Clinic Transformation Steering Team
(Mike Metcalf, Doug Watson, Scott Foster, Robin Virgin, Michelle Budd, Cynthia Fintner, Program Manager TBD)

Clinic Transformation Work Group
Michele Budd, Doug Watson, Scott Foster, Robin Virgin, Program Manager, Network Dyads, Physicians and Other SMEs TBD

Network Operating Committees
Thank you for your time and attention!