Evolution of an Ambulatory Care Management Model as Part of Patient-Centered Medical Home

Sentara Medical Group

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Vice President, Nurse Executive
Sentara Medical Group
OBJECTIVES

• Describe the development and implementation of a comprehensive ambulatory RN Care Management and Coordination model designed for targeted patient populations within a large integrated healthcare system’s multi-specialty medical group.

• Compare and contrast the impact of ambulatory RN Care Managers on all-cause medical admissions, all-cause medical readmissions, Emergency Department visits, perceptions of mental and physical health, advance care planning, and the total of cost of care for targeted populations of complex, chronic disease patients.

• Describe the innovative strategies used to further evolve the ambulatory RN Care Management model to include Population Health RNs to provide chronic disease management and prevention of progression.
Sentara Healthcare

- Integrated Healthcare System
- Southeastern Virginia, Northern Virginia, Western Virginia, and Northeastern North Carolina
  - > 2 million in Hampton Roads
  - > 500,000 in Blue Ridge
  - > 375,000 in Northern Virginia
Sentara Healthcare

- 126-year Not-for-Profit Mission
- 27,000+ Members of the Team
- 12 Hospitals; 2,727 Beds; 3,799 physicians on Staff
- 13 Long-Term Care/Assisted Living Centers
- Extended Stay Hospital
- Sentara College of Health Sciences
- Sentara Home Health
- Sentara Health Plan (Optima)
- Sentara Medical Group
About Sentara Medical Group

- 180 practice locations
- 800 primary care and specialty physicians, nurse anesthetists and advanced practice clinicians
- Over 600,000 patients served in the past 24 months across Northern Virginia, Southeast Virginia and Northeast North Carolina
- 18 specialties
- Largest group within SQCN – Sentara Quality Care Network comprised of ~2400 providers
- PCMH – 38 Level 3
  - Diabetes - 96
  - Heart Stroke - 78
## Sentara Medical Group Payor Mix

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*Sentara has a Medicare Advantage program and a Clinical Integrated Network (CIN)- SQCN*
Example of Crisis Management

In healthcare, we are looking at major changes in the immediate future. We are moving from fee for service to value based reimbursement.

How are we going to manage populations? How can we do all this and still see our patients?

Our situation is not life or death but still needs to be addressed with a sense of urgency.

This is an example of crisis management with some lessons we can learn.
“Good Friday Miracle”

Miracle - an effect or extraordinary event in the physical world that surpasses all known human or natural powers and is ascribed to a supernatural cause.
We can attribute this to a higher power and I cannot argue about that. My focus today is on the “lower powers” that managed the crisis with exceptional skill and with disregard for their own personal safety.
F/A-18 Super Hornet
• 60’ long

Boeing 737
• 120’ long
High Alpha
Lessons Learned

• The pilots did not panic. They did what they were trained to do.

• Preparation is key. If you are prepared for challenges and change, you can adopt much easier.

• They worked as a team to overcome their challenge. In healthcare, we need to do the same.

• Realize that even if the situation looks hopeless, act and don’t be resigned to fate or outside influences.
Guiding Principles and Goals

**Guiding Principles**

- Patient-Centered
- Data Driven Decision Making
- Standardization
- Practice at Highest Level of Clinical License

**Goals**

- Improved Clinical Outcomes
- Increased Patient Access
- Provider/Staff/Patient Satisfaction
- Performance Improvement of Operations – Bend the Cost Curve
Building the Care Model

• 2007-2009 Implemented EMR (EPIC)

• 2009-2011
  – Dedicated approach to redesign work
    • Transformation of Care Team established
    • Guiding Principles established
    • NCQA PCMH provided framework for expansion
    • Piloted embedded and telephonic Care Management Model (2011)

• 2012
  – Care Model Established and Expanded
    • Practice standardization
    • All Primary Care in Hampton Roads region
    • Care Management redesign - “hybrid” model high cost high utilizer

• 2013
  – Pharm D and Social work
  – Care Management evolved into intense transition care management and other targeted patient population

• 2014
  – Ongoing evolvement of care management services to support population management
Someday we'll catch that laser pointer...
Essential components of office redesign

- Efficiency and standardization
- Monthly Medical Home meetings
- NCQA Recognitions
  (PCMH- 38 All Level 3, DM- 81, HS- 63)
Redesign Body of Work

- Define roles and responsibilities
- Same Day appointments
- Care Management
- Best Practice Advisories
- Report Cards
- Chronic disease registries
- Preventive Care Outreach
- Standardized workflows & Care processes
- Transition of Care - 7 day hospital f/u
  - Hospitalist/PCP/Specialty Collaboration
  - Medical Neighborhood meetings
  - Primary Care Note
  - Service Agreements
- PharmD
  - Perform chart review
- Advance Care Planning
- Integration of Behavioral Health
- Utilization review – ED/Readmissions
- Patient Experience
- Generic Prescribing Initiative
- Care Plans
- Huddles
- Alternative Visits
  - Group visits
  - Evisits
  - Virtual visits (MDLive)
- Clinical Summaries
- Medical Home Meetings
  - Innovation and best practice sharing
  - Review report card
  - Performance improvement
  - Multidisciplinary team
- Referral tracking
- Patient Portal
Medical Home Meetings

- Multidisciplinary team
  - Home health, Optima & Sentara care managers, lead nurse
- Standard monthly agendas
- Case Management case reviews - Optima and Sentara
- Readmission cases - local vs system issues identified
- Scorecard review with practice - provider & patient level data
- Action steps for scorecard areas of opportunity
- Innovation and best practice sharing
  - Shared learning with specialist
Data drives performance

Practice Scorecard

✓ Interactive scorecard for every practice

✓ Practice, Provider and Patient level data

✓ Reviewed Monthly with action steps
## Example of Practice Report Card

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<th>Measures</th>
<th>2013 Base</th>
<th>Score</th>
<th>2014 Goal</th>
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<td>3. DM BP &lt;140/90 **</td>
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<td>8. Pneumovax **</td>
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<td>9. Patient Satisfaction **</td>
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<td>18. ED Visits by PCP of Record (LFM)</td>
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<td>2.50%</td>
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**Designates Comp Measures (AVS - FM; Smoking Cessation - IM)

Blanks identify unavailable data or goals under evaluation.
Build and Sustain Culture with Team Engagement

“Carefully designed, evidence-based care processes, supported by automated clinical information and decision support systems, offer the greatest promise for achieving the best outcomes from care for chronic conditions” (IOM, 2001)

- Physician Clinical Protocol Committee (PCPC)
- Practice workflows and processes
- Disease focused Care Plans and Best Practice Advisory
- Registry management
- Manager Provider Dyad
- Multidisciplinary focus on improvement
- Leadership development

When radiologists take a selfie
Journey to Population Management

Cutting Edge 2 Pilots
VIPs
New Model
10 Sites  
2011

Early Adopters

Spread of Best Practices across SMG
Intense Transition
Clinical 3
Medical Discharges
ED 1st Call  
2013

Standardization across SMG
48 Sites
Medicare Advantage Pharmacy
Social Work  
2014

Care Model Expansion and Innovation
Targeted Populations
CCM
Medicare Advantage  
2015

AMGA
2015 Institute for Quality Leadership
Vision and Goals for SMG Care Management

**VISION**
Improve the health and well-being of our patients in the communities we serve

**GOALS**
- Reduce ED Visits
- Reduce Admissions
- Reduce Readmissions
- Improve Quality of Life
- Reduce Total Cost of Care
- Reduce Total Cost of Care
- Improve Staff Satisfaction
- Improve Clinical Outcomes
- Improve Patient Satisfaction
- Facilitate Advanced Care Planning

SMG Patients

2015 Institute for Quality Leadership
Complex Chronic Disease

Manage Chronic Disease/Conditions and Prevent Progression

Prevent Chronic Disease/Conditions, Identify and Prevent Progression

Health Maintenance, Ongoing Acute and Preventive Medical Care
VIP Population
(Very Important Patients)

TOP OF THE PYRAMID

942 of 2591 Total VIP
260 VIP Sentara (VIPS)
192 VIP Optima (VIPO)
306 VIP Indigent/Self-Pay (VIPIS)
122 Current VIPS
62 Current VIPIS
Transition - VIPT
VIP Population

- Chronic Diseases and/or Conditions
- Benefit from “intense” community-based Care Management
- Currently not engaged with Case Management services (except Optima)
SMG Care Management

- Chronic Diseases and/or Conditions
- Post-hospitalization/medical discharges
- At-Risk
- Rising-Risk
- Benefit from community-based Chronic Care Management (CCM) not Complex Chronic Care Management (CCCM)
- Payor-Based (Incentives, At-Risk Agreement)
- Prevention of Chronic Disease/Conditions, Identify and Prevent Progression
High Cost/High Utilizers

- RN Ambulatory Care Management Model
- Very Important Patients (VIPs)
- Flags and Metrics (Scorecards)
- Patient-Centered Medical Home (PCHM)
- Advanced Care Planning
- Past Utilization
SMG RN Care Management

- SMG PCP Sites
- PCMH
- RN Care Managers
- RN Population Health Management
- Team-Based Care
SMG Care Management Targeted Populations

- Payer
- Medicare/Medicare Advantage
- Senior, Adult, and Pediatrics
- Disease/Condition (e.g. CHF Class 2, Diabetes A1C 6-9, Behavioral Health, Pain, etc.)
- Prevent Chronic Disease/Condition based on Risk Factors – Key Component
SMG RN Care Management
Radically Different Model
SMG RN Care Manager – Role

• Establishes and maintains patient-centered relationships
• Conducts comprehensive initial assessments
• Identifies and determines needs
• Develops Plans of Care
• Conducts ongoing clinical assessments and monitoring of patient status
• Provides coaching, education, and support
• Manages resources (e.g. medications, referrals, transportation)
• Manages transitions of care
• Conducts Advance Care Planning
SMG RN Care Management

- Job Descriptions – BSN and Certification Requirements
- Core Competencies
- Patient Lists by Populations
- Assignments
- Expectations
- Patient Letter from PCP
- Engagement
- Contact Letter, Brochure
- Work Flows
- SMG, Optima (Health Plan), and CIN EMR
- Meetings with HH and Inpatient CC
- Education/training
SMG RN Care Management

• 150 (avg) VIP/MHCM
• + New “enrollees” from VIPx List identified as candidates for CM at later date
• CHF, Pneumonia, AMI, COPD, Diabetes, Renal to Medical
• Transition
RN Care Management Strategies

- ED Visits or Hospitalizations ≥ 3/year → First-call Strategy with MHCM
- Intense Transition Management → Post-Discharge → Medical (Surgical) → 30+ Days (90+) → Payors
SMG Care Management Outcomes

- ED Treat and Release Episodes
  ↓ 41%
- All-Cause Admissions
  ↓ 46%
- All-Cause Readmissions
  ↓ 19%
- 7-Day Follow-Up
  ↑ 76%
- Total Cost of Care
  ↓ 17%
- Advanced Care Plan
  ↑ 23%
SMG Care Management Outcomes: SF 12

- Functional and Psychological Health
- Pre and Post RN Care Manager Engagement
- 48% Improvement 1st Stages Depression
- 6% Improvement Physical Health
- 43% Improvement Mental Health
SMG Care Management Patient Satisfaction

- > 93% agree overall health status and access has improved
- > 96% agree they get help when needed
- > 96% agree understanding and knowledge of condition/disease has improved
- > 96% satisfied with MHCM care and services
SMG RN Population Management

- Job Profile – RN Population Health Management
- Core Competencies
- Risk Stratification
- Assignments
- Expectations
- Engagement
- PCP Letter/Brochure
- Work Flows
- Education/Training
- Specialty Certification
SMG RN Population Health Management– Role

- Establishes and maintains patient-centered relationships
- Conducts initial and ongoing assessments
- Identifies and determines needs
- Develops Plan of Care with patient
- Provides coaching, education, and support
- Coordinates resources (e.g. medications, referrals, transportation)
- Manages registries for care opportunities
- Conducts pre-visit planning for Care Team
- Identifies at-risk and rising risk patients (risk factor stratification)
- Provides transition management and patient triage
- Refers complex patients to RN Care Managers
- Facilitates Advance Care Planning
RN Population Health Management

- 300-500 Patients
- Rising-Risk
- Gap Closure
- Telephonic
- Multiple Practices/Providers
Data Toolkit
SMG RN Care Management Tools

- Chronic Disease Registries
- 30-Day Re-admissions
- ED Visits
- 7-Day Post-Hospital Discharge
- Care Manager Productivity
- “My List”
- Admission, Discharge, Transfer (ADT)
### Diabetic Patient Registry ~ All Indicators

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<th>PCP</th>
<th>Last Known Visit with PCP Dept</th>
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<th>Last HbA1c Value</th>
<th>Last LDL Value</th>
<th>Systolic</th>
<th>Diastolic</th>
<th>Aspirin</th>
<th>Smoking Status</th>
<th>Foot Exam Status</th>
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# 30-Day Readmission

## SMG BAYSIDE FAM PRAC

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<tr>
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<th>MRN</th>
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<th>DOB</th>
<th>Age</th>
<th>Insurance</th>
<th>Admission Date</th>
<th>Discharge Date</th>
<th>Admitting Diagnosis</th>
<th>DIFF</th>
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<td>02 MEDICARE</td>
<td>**</td>
<td>GLH</td>
<td>07/26/2014</td>
<td></td>
<td>CHEST PAIN</td>
<td>07/20/2014</td>
<td>07/23/2014</td>
<td>CELLULITIS OF RIGHT HIP CELLULITIS OF RIGHT HIP</td>
<td>0</td>
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<tr>
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<td>**</td>
<td>GLH</td>
<td>07/19/2014</td>
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<td>07/23/2014</td>
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<tr>
<td>02 MEDICARE</td>
<td>**</td>
<td>SLH</td>
<td>07/26/2014</td>
<td></td>
<td>CHEST PAIN</td>
<td>07/28/2014</td>
<td>07/30/2014</td>
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<td>29</td>
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<td></td>
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<td>**</td>
<td>SLH</td>
<td>06/27/2014</td>
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<td>07/03/2014</td>
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</tbody>
</table>

| ANDERSON, ROBIN N |     |              |     |     |                 |                |                |                                      |      |
| No of Patients Re-admitted: | 6     |              |     |     |                 |                |                |                                      |      |
| No of Patients Re-admitted with SMG PCP: | 36     |              |     |     |                 |                |                |                                      |      |

**AMGA**

2015 Institute for Quality Leadership

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## ED Visits for Patients with an SMG PCP Provider

**Report Data For 7/1/2014 to 7/31/2014**

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>MRN</th>
<th>DOB</th>
<th>PCP Name</th>
<th>Payor</th>
<th>Admission Date</th>
<th>Dis Date</th>
<th>ICD-9 Code</th>
<th>Encounter Diagnosis</th>
<th>D/C Disposition</th>
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<tbody>
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<td>ANTHEM BLUE CROSS/BLUE SHIELD</td>
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<td>07/01/2014</td>
<td>020</td>
<td>Hoot contusion</td>
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<td>07/14/2014</td>
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<td>Cholelithiasis</td>
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<td>ANTHEM BLUE CROSS/BLUE SHIELD</td>
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<td>Concussion, unspecified</td>
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<td>ANTHEM BLUE CROSS/BLUE SHIELD</td>
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<td>Influenza B</td>
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Follow-up Visits within 7 Days of Hospital Discharge

<table>
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<tr>
<th>SMG PCP ANNE FAM PRAC</th>
<th>Patient Name</th>
<th>DOB</th>
<th>Patient MRN</th>
<th>Hospital Disch Time</th>
<th>Hospital Disch Provider</th>
<th>Called?</th>
<th>Completed</th>
<th>Next Appointment Date</th>
<th>Next Appot Time Diff</th>
<th>Next Appot Visiting Provider</th>
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<tr>
<td>MANTAY, KRISTI M</td>
<td></td>
<td></td>
<td></td>
<td>7/25/2014 6:28:00PM</td>
<td>Atchley, William D</td>
<td>yes</td>
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<td>151</td>
<td>MANTAY, KRISTI M</td>
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<tr>
<td>OLD, WENDY R</td>
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<td></td>
<td></td>
<td>7/25/2014 12:59:00PM</td>
<td>Mirza, Alamgir</td>
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<td>08/1/2014</td>
<td>6</td>
<td>MANTAY, KRISTI M</td>
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Report Total: 2 2 100.00% 2 100.00% 1 50.00%
### RN Care Manager Productivity Report

**My Health Care Coordination Information**

Report Data For 7/20/2014 to 7/26/2014

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<th>Patient MRN</th>
<th>Patient Name</th>
<th>Date of Birth</th>
<th>First Discharge Date</th>
<th>Second Encounter Date</th>
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**Patients who had a Phone Contact within 2 days of Discharge**

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<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
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<td>3</td>
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<td>0.33</td>
<td>0.00</td>
<td>0.33</td>
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Evolution of SMG RN Care Management Model

2010: PCMH

2011: RN Care Manager (2) Embedded and Telephonic in 2 PCP Sites, CHF

2012: RN Care Managers (5) – Multiple Practices, Multiple Encounter Types 11 Sites, VIP (High Cost/High Utilizers) with Complex, Chronic Diseases/Conditions

2013: Intense Transition Management; 39 Sites, Medical Discharges from Hospital/ED (9 RN Care Managers, 1 SW)

2014: Risk Stratification Processes and Payer (MAA) Population Management; Utilization-Focused (14 RN Care Managers, 1 SW)

2015: RN Population Health Management; PCP Office, Complex Diseases/Conditions, Rising-Risk, Disease Management and Progression Prevention
Lessons Learned
I have made a terrible mistake
Leadership Lessons Learned

- Hire
- Position Fit
- Personality
- Autonomy
- Team
- Provider-Care Manager Expectations
- Role Clarity
- Data
- Space
- Technology