When it comes to post acute care transition, how big of a team are you playing on to ensure patient safety?

Betsy Chang Ha, RN
Nancy Yu, MD
Presenter Introduction

Betsy Chang Ha, RN, MS
Vice President, Clinical Practice Excellence

Nancy Yu, MD, CPE
Regional Senior Medical Director, Achieving Clinical Excellence
Outline

1. Who We Are
   - Mission and Vision
   - Geographic Footprint
   - Care Delivery Organizations

2. OptumCare Model

3. Transitional Care Management National Initiative
   - Patient Story

4. One Care Delivery’s Journey
   - SMA TCM lean Process Improvement

5. Q&A
Objectives

Upon completion of this activity, participants should be able to:

- Define the role of primary care providers and the ambulatory care team as part of a risk-bearing entity.
- Apply Lean methodology and culture change strategies to spread adoption of evidence-based practice in transitions of care.
- Leverage the transitional care management core process to identify high-risk patients and refer them to appropriate clinical programs in the ambulatory setting.
- Use key process indicators and outcome data to improve transitions of care.
Our Mission

Optum® is a health services and innovation company that powers modern health care by combining data and analytics with technology and expertise.

Mission:
Helping to make the health system work better for everyone.
OptumCare is a physician led, patient centered, data driven delivery system that supports management of medical care, risk & operations by offering a breath of services and tools for local health care needs.
OptumCare’s Geographic Footprint is Growing

350+ Clinics | 44 States | 150 Health Plans | 17,000 Physicians | 6.9M Consumers Touched
OptumCare Delivery – Who We Are

Care Delivery IPAs and Physician Practices

Local Care Delivery Markets
OptumCare Delivery – Who We Are

- Independent Practice Associations (IPA)
- Medical groups
- High-performing delivery networks
- Continuum of care services
- Risk Bearing Entities

<table>
<thead>
<tr>
<th>Profile</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Care Delivery Markets</td>
<td>21</td>
</tr>
<tr>
<td>Number of Contracted Payers</td>
<td>19</td>
</tr>
<tr>
<td>Capitated Patients Under Management *</td>
<td>~1M</td>
</tr>
<tr>
<td>Employees</td>
<td>~11,000</td>
</tr>
<tr>
<td>Total Physicians</td>
<td>~17,000</td>
</tr>
<tr>
<td>Primary/Urgent Care Clinics</td>
<td>~200</td>
</tr>
<tr>
<td>OptumCare Revenue</td>
<td>~$4 B</td>
</tr>
</tbody>
</table>
Our Care Model

Managing the Health of our Population

Creating Personal Care Experience
- Patient and PCP Relationship
- Care Team Support
- Coordinate Care

Aligning with our Community

1. Patient Identification and Stratification
2. Evidence-based Interventions
3. Patient Engagement
4. Reporting and Outcomes Evaluation

Addressing the medical, social and behavioral needs of the people we serve
Transitional Care Management Process National Initiative
## Mary

<table>
<thead>
<tr>
<th>Bio</th>
<th>Family</th>
<th>Health</th>
<th>Chronic Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>75 years old, living in Phoenix, AZ</td>
<td>Widowed with three adult children in town, but she lives alone</td>
<td>Readmitted to the hospital twice in three months</td>
<td>Lives with diabetes and COPD, after a life long struggle with cigarettes</td>
</tr>
</tbody>
</table>
Health care experts have a clear understanding that unmanaged, post-acute care transitions to home or a skilled nursing facility can lead to avoidable readmissions, serious quality problems and unnecessary medical costs.

Models across the nation have leveraged best practices which have successfully led to readmission reductions after patients have been discharged.

1 in 5
Medicare patients that are discharged from the hospital are readmitted in less than a month

$17 billion
Is the estimated annual cost of avoidable readmissions
OptumCare Roadmap from FFS to Global Risk

Fee For Service → ACO/Gain Share → Shared Risk → Full Risk → Global Risk
What is MACRA?

- **The Medicare Access & Chip Reauthorization Act of 2015:**
  - Signed into law in April of 2015
  - Legislation passed to replace the Sustainable Growth Rate (SGR)
  - Proposed to be implemented 1/1/17
  - Many provisions impacting Medicare

- **CMS Intent:**
  - Move traditional Medicare fee-for-service reimbursement toward value-based purchasing
  - Streamline multiple quality reporting programs into one Merit-Based Incentive Payment System (MIPS)
  - Create incentives for improved quality, interoperability, and reduced costs
  - Create incentives for providers to seek value-based contracts with other payers
  - Provide fee schedule updates (0.5% between 2016-2019, and 0.25% in 2026+)
Who Will Participate in Different Payment Approaches?

Subject to MIPS

Not in APM

In non-Advanced APM

In Advanced APM, but not a QP

Qualifying Providers in Advanced APM

Some people may be in Advanced APMs but not have enough payments or patients through the Advanced APM to be a Qualifying Provider (QP).

QPs = Qualifying Providers
Initial Performance Category Weights for MIPS

- **COST**: 50%
- **CLINICAL PRACTICE IMPROVEMENT ACTIVITIES**: 15%
- **ADVANCING CARE INFORMATION**: 25%
- **QUALITY**: 10%

COST

10%

CLINICAL PRACTICE IMPROVEMENT ACTIVITIES

15%

ADVANCING CARE INFORMATION

25%

QUALITY

50%
Why TCM?
Six Best Practices in Care Transition

1. Comprehensive discharge planning
2. Complete and timely communication of information (i.e., 2 Business Days PDC Contact)
3. Medication reconciliation
4. Patient/Caregiver education using the “teach back” method
5. Open communication between providers (i.e., Inpatient and outpatient providers)
6. Prompt follow-up visit with an outpatient provider after discharge

*Center for Healthcare Research and Transformation
Journey Map 2014 to 2016

**PAST**
- Independent Free-standing Models

**2014**
- Measurement, Baseline and Benchmarking

**2015**
- Post Acute Transitional Care Management (TCM)

**2016**
- Linking TCM to Person-centered Chronic Illness Care Programs
- Expand TCM to include SNF

**2017**
- Standardized Clinical Operations, Programs, and TCM process
- Spread OptumCare Care Model

**2018**
- Achieve Clinical Practice Excellence

**FUTURE STATE**
- Unified Integrated Care Model
30 Day Acute to Acute Readmit Rate

- Report reflects Senior global risk population for all health plans for Monarch, NAMM, OCAZ, SMA, WellMed except for AppleCare (CMC Dual Risk). OCUT is excluded due to new data source conversion.
- Readmit rates are based on either authorization data (if available) or claims data posted through July 2016.

<table>
<thead>
<tr>
<th></th>
<th>Applecare</th>
<th>Monarch</th>
<th>NAMMCA</th>
<th>OC AZ</th>
<th>SMA</th>
<th>WellMed SA</th>
<th>WellMed GTX</th>
<th>WellMed FL</th>
<th>OptumCare</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>13.2%</td>
<td>10.3%</td>
<td>12.5%</td>
<td>12.5%</td>
<td>13.9%</td>
<td>12.2%</td>
<td>12.8%</td>
<td>15.7%</td>
<td>13.1%</td>
</tr>
<tr>
<td>YTD 2016</td>
<td>13.2%</td>
<td>11.9%</td>
<td>13.4%</td>
<td>13.3%</td>
<td>14.9%</td>
<td>12.3%</td>
<td>13.5%</td>
<td>15.5%</td>
<td>13.7%</td>
</tr>
</tbody>
</table>

Goal
One Care Delivery Organization’s Transition of Care Journey

Dr. Nancy Yu
Regional Senior Medical Director
Process Improvement
Clinical Informatics
SMA - Nevada’s Largest Multi-Specialty Group

- 350+ providers
- 30 clinic locations
- 340,000+ patients
- Six urgent care locations
- Seven convenient care locations
- Two Ambulatory Surgery Centers
- 4,200,000+ patient contacts in 2015
- Medicare Advantage Global Risk
- Commercial and Medicaid Professional Risk
Southwest Medical: Achieving Clinical Excellence

- Supports organization-wide continuous process improvement using Lean Methodology
- Embeds problem-solving capabilities within organization
- Kaizen Promotion Office

Department Mission:
- We foster a culture of continuous improvement in pursuit of the perfect patient experience

Department Vision:
- To be the foundation of patient centered cultural transformation
# What is Lean Methodology?

<table>
<thead>
<tr>
<th>Systematic Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eliminate Waste</td>
</tr>
<tr>
<td>Increasing value from the customer’s perspective</td>
</tr>
<tr>
<td>Improving Processes</td>
</tr>
<tr>
<td>Tools and Management System</td>
</tr>
</tbody>
</table>
Lean Improvement Cycle

1. Select the product/service based on value add to patient

2. Observe, understand & complete the current state Value Stream Map

3. Envision and draw a waste-free future state Value Stream Map

4. Create and implement the improvement plan
Our Transition of Care Problem

<table>
<thead>
<tr>
<th>Year</th>
<th>Admits/K</th>
<th>Readmit Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>211</td>
<td>14.8%</td>
</tr>
<tr>
<td>2013</td>
<td>221</td>
<td>16.1%</td>
</tr>
</tbody>
</table>
Problem Statement:

• Nearly 20% of patients will experience an adverse event within 30 days of discharge, resulting in high readmission rates and emergency department visits.

• A significant portion of these can be prevented with improved, consistent, transition of care plans, including prompt follow up visits with PCP (recommended within 7 days of discharge).

*New England Journal of Medicine (April 2009), “Rehospitalizations among Patients in the Medicare Fee-for-Service Program”*
1 – Select the Product or Service

Problem Statement
Despite adequate HFU appointment slots, current seven-day hospital follow up rates are 43% (YTD, Sr. D). The readmission rate is targeted by SMA to be below 12%. At 16.1% (Sr. D.), the readmission rate target is not being met.

Goal Statement
Increase the percentage of SMA patients who have a 7-day hospital follow up visit from 43% to 70%.
2 – Observe and Depict the Value Stream Map
3 – Observe and Draw the Current Value Stream Map

- High degree of complexity
- Duplication of effort
- High variability

**Hospital**
- Medical attention
- Transition of care initial contact (CM)
- Discharge planning

**Home**
- Recovery

**Scheduling**
- Multiple processes
- Medical Management, Clinic, patient initiated, hospital initiated

**Appointment**
- Arrives at PCP for follow up appointment

- 4 days
- 2 days
- 2 days
- 55 minutes
- 5 minutes
Identified Process Issues:

1. Multiple departments
2. Patient Information
3. Appointment Scheduling

Identified Impact:

- Over-Processing
- Defects Inventory
- Over-Processing + Defects
### Identified Workflow Issues:

<table>
<thead>
<tr>
<th>Identified Workflow Issues</th>
<th>Identified Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information Flow</td>
<td>Time + Defects</td>
</tr>
<tr>
<td></td>
<td>Delays and Inconsistent information</td>
</tr>
<tr>
<td>Workflow</td>
<td>Over-processing</td>
</tr>
<tr>
<td></td>
<td>Substantial rework</td>
</tr>
<tr>
<td>Variation</td>
<td>Over-processing + Defects</td>
</tr>
<tr>
<td>Inconsistencies</td>
<td>Substantial rework, incomplete information and missed appointments</td>
</tr>
</tbody>
</table>
Hospital Follow Up Appointments

Jan – Sep 2014 Discharges
SrD Emergent Admits

No follow up appointment for > 30 days: 1019 pts

Arrived to appointment within 7 days: 2021 pts

Arrived to appointment within 7 and 30 days: 1618 pts

Within 7 days: 43%

8 to 30 days: 35%

No appt: 22%

APR 78%
No follow up appointment for >30 days: 1019 pts

We’re reaching 92% of all senior dimensions discharges

ARRIVED 25%
CANCELLED 14%
NO SHOW 9%
Other 16%
NONE 37%
Process Improvement Potential

$1.8M to $4.3M
Cost Savings Potential

*Based on a typical inpatient stay cost of $11,000.
Using a 2 percentage point improvement (from 16.1% to 14%) and an $11,000 average cost – cost savings can be calculated to $1,793,000.
Assuming a 4 percentage point improvement, from 16.1% to 11% (the 2014 CMS 4-star rate) – cost savings can be calculated to $4,300,000.
Hospital Follow Up Future State Appointment Process

- **Hospital**
  - Medical attention
  - Transition of care initial contact (CM)
  - Discharge planning

- **Home**
  - Recovery

- **Inbound Call**
  - Patient Services (Call Center) standard work

- **Outbound Call**
  - Medical Management standard work

- **Clinic**
  - Discharge Notification standard work

- **Appointment**
  - Arrives at PCP for follow up appointment
4 – Create and Implement Improvement Plan

HFU 2-Day Kaizen Event

**Goal:** Develop standard work for Inbound and Outbound Hospital follow up call

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
<th>Time</th>
<th>Screen shots / Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Setup</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>a. Sign in to ACM, Touchworks, IDX and Center</td>
<td>01:49</td>
<td></td>
</tr>
<tr>
<td></td>
<td>b. Obtain discharge list from ACM</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>c. Sort discharge by disposition, looking for discharges to home or home with home health</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>d. Develop list of patients to be contacted</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>e. Obtain patient info one by one</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>f. Look for: open TOC tasks, DME orders, Home Health orders</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>g. Confirm any existing appointments in Touchworks</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>h. Confirm acuity and PCP in Touchworks</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>i. If patient is IDT, send a task to IDT team to schedule appointment - END process</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>j. If existing appointment, is it within recommended (7 calendar days post discharge date) time frame? Yes, go to step 3. No, Goto Step 2.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outbound Call</strong></td>
<td></td>
<td>00:47</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Access patient MRN in IDX. Make outbound call. Goto Step 4 (no answer) or 5 (answer)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Call patient to confirm existing date, time and location – Go to Step 19</td>
<td></td>
<td>Only if existing appointment within 7 day timeframe</td>
</tr>
</tbody>
</table>
3 – Envision a Waste Free Future State

- **Patient**
  - Facets
  - ACM
  - Touchworks
  -IDX
  - Connect R

- **Hospital**
  - Medical attention
  - Transition of care initial contact (CM)
  - Discharge planning

- **Home**
  - Recovery

- **Inbound Call**
  - Patient Services (Call Center) standard work

- **Outbound Call**
  - Medical Management standard work

- **Clinic**
  - Discharge Notification standard work

- **Appointment**
  - Arrives at PCP for follow up appointment
4 – Create and Implement Improvement Plan

HFU 2-Day Kaizen Event

Problem:
No standard mode of communicating discharge issues from Medical Management to Adult Medicine clinics.

Goals:
Sort, simplify, and standardize communication between departments handling hospital follow up appts

Define adult medicine responsibilities once appointment is made with follow through for no-shows.
Observations from Kaizen #2

• Multiple IT systems
• No communication between departments
• Too much unnecessary information
• Variation in processes
• No visibility
• Inability to track causes for no-show or missed appointments
## 4 – Create and Implement Improvement Plan

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
<th>Valid Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sweep</strong></td>
<td>Twice per day (AM and PM)</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Review Provider Support box <strong>and</strong> Provider Term box to look for <em>Discharge Notification</em> tasks</td>
<td>Y, N, OOS</td>
</tr>
<tr>
<td>2</td>
<td>A Sort by task type, look for <em>Discharge Notification</em> task</td>
<td>Y, N, OOS</td>
</tr>
<tr>
<td></td>
<td>B If task is sent to Provider Term box, delegate/reassign to appropriate Provider support or Team support box.</td>
<td>Y, N, N/A, OOS</td>
</tr>
<tr>
<td><strong>Action</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>A Open <em>Discharge Notification</em> task - view which actions are needed.</td>
<td>Y, N</td>
</tr>
<tr>
<td></td>
<td>B Open discharge summary in chart if available. Review orders.</td>
<td>Y, N, N/A</td>
</tr>
<tr>
<td></td>
<td>C <strong>If appointment is needed</strong> ➔ call patient, go to Step 4.</td>
<td>Y, N, N/A</td>
</tr>
<tr>
<td></td>
<td>D <strong>If appointment has been scheduled</strong> and other follow up is needed, call patient (except if requesting medical records only). Go to Step 6.</td>
<td>Y, N, N/A</td>
</tr>
</tbody>
</table>

**Adult Medicine Discharge Process Standard Work**
## 4 – Create and Implement Improvement Plan

<table>
<thead>
<tr>
<th>Audit Period</th>
<th>Jun 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audit Sample Size</td>
<td>47</td>
</tr>
<tr>
<td>Defect Rate</td>
<td>0%</td>
</tr>
<tr>
<td>% Appts Scheduled in 7 days</td>
<td>93.2%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SETUP</th>
<th>Total Defects</th>
<th>Defect Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>f</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>g</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>h</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>i</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>j</td>
<td>0</td>
<td>0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OUTBOUND CALL</th>
<th>Total Defects</th>
<th>Defect Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>0%</td>
</tr>
</tbody>
</table>

**Sustaining standard work through audits**

- f: Look for: open TOC tasks, DME orders, Home Health orders
- g: Confirm any existing appointments in Touchworks
- h: Confirm acuity and PCP in Touchworks
- i: If patient is IDT, send a task to IDT team to schedule appointment - END process
- j: If existing appointment, is it within recommended (7 calendar days post discharge date) time frame? Yes, go to step 3. No, Go to Step 2.
- 2: Access patient MRN in IDX. Make outbound call. Go to Step 4 (no answer) or 5 (answer)
- 3: Only if existing appointment within 7 day timeframe
- Only if existing appointment within 7 day timeframe
- Call patient to confirm existing date, time and location – Go to Step 19.
- 3: 0 | 0%
Weekly Value Stream Audits

Information flow is the largest source of defects.

Target Rate

Bar chart showing defect rates across different categories:
- TOTAL DEFECT RATE
- Information
- Med Mgmt
- Patient Services
- Adult Med

Defect rates range from 0% to 50%.
Measuring Our Improvement

HFU in 7 Days

Goal Rate

2014: 46%
2015: 53%

15% improvement YOY
Reassessing Ourselves

<table>
<thead>
<tr>
<th>Year</th>
<th>Admits/K</th>
<th>Readmit Rate</th>
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<tbody>
<tr>
<td>2012</td>
<td>211</td>
<td>14.8%</td>
</tr>
<tr>
<td>2013</td>
<td>221</td>
<td>16.1%</td>
</tr>
<tr>
<td>2014</td>
<td>199</td>
<td>14.3%</td>
</tr>
<tr>
<td>2015</td>
<td>197</td>
<td>14.5%</td>
</tr>
</tbody>
</table>
Root Cause Analysis Tool – Why Aren’t Patients Scheduling in Seven Days?

<table>
<thead>
<tr>
<th>Created</th>
<th>Dept</th>
<th>Location, Clinic Only</th>
<th>MRN</th>
<th>Reasons</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/08/15 11:27 AM</td>
<td>Patient Svcs</td>
<td></td>
<td>998095</td>
<td>Other</td>
<td>Pt missed 7 days of other Facility. States will call to reschedule.</td>
</tr>
<tr>
<td>10/08/15 10:13 AM</td>
<td>Med Mgmt</td>
<td></td>
<td>3189133</td>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>10/08/15 10:05 AM</td>
<td>Med Mgmt</td>
<td></td>
<td>1817750</td>
<td>Wants specialty appt first</td>
<td></td>
</tr>
<tr>
<td>10/08/15 08:29 AM</td>
<td>Patient Svcs</td>
<td></td>
<td>3932666</td>
<td>PCP only</td>
<td></td>
</tr>
</tbody>
</table>
Identify Why Patients are Outside Seven Day Window

Bar chart showing reasons for patients being outside the seven-day window:
- Called in for appt past 7-days
- PCP only
- Other
- Transportation
- Out of town
- Out of Network PCP
- Refused alternate options
- Readmission
- Acuity interference (access issues)
- Provider refused double book
- Pt. refused (please add Why in comments)
HFU Missed 7 Day Tracker

- Unable to Contact: 34%
- Pt. Refused: 9%
- PCP Only: 17%
- Other: 7%
- IDT/CarePlus PT: 7%
- Called In for Appt Past 7 Days: 7%
- Want Specialist Appt First: 4%
- Deceased/Hospice/Transferred to other Facility: 18%
Other Category 2016

- Prescheduled Appt: 22%
- Out of Town: 8%
- No Reason: 10%
- Network/Specialist Doc/VA: 8%
- Misc.: 9%
- Scheduling Conflict: 14%
- Readmit: 11%
- Pt. Refused: 10%
- Program: 8%
Arrived to Appointment in 7 Days

*2016 is August YTD
Admits/K

*2016 is August YTD
Readmits/K

*2016 is August YTD
Where We Are Now, Where We Are Going
Preventing Readmission is Multi-Pronged: Next Steps in Motion

- Root Cause Analysis of Readmission Patients
- Value Stream Map and Standard Work Development of Ambulatory Case Manager in Transition of Care
- Palliative Care Program
- Redesign the hospital follow-up appointment at the outpatient clinic level
Case Manager Kaizen Event, 11/8 – 11/10
Thank You

Questions?