My Story of Getting from Here to There

The Journey of a Transformed Specialty Practice
Do you feel like this?
Starting thoughts

• What do you love about what you do? (related to your career in medicine)

• What gets in your way or makes it hard to do what you love in medicine?
Health care delivery in the USA

IOM CQC summary
• Highly Specialized
• Compartmentalized
• Disorganized
• Fragmented
• Falls short on measures of clinical quality

Underlying characteristics
• Acute care model
  – Staccato care
  – ER model
• Physician centered
  – Physician carries the load & responsibility
  – Staff supports physician
• Silos of care
  – Separated care providers
  – Disconnected care
Case 1 ("Playing Charades")

- 70 year old woman from town 2 hours away, doesn’t know why she was referred
- No records
- Only voice mail at referring practice
- What to do?

- What I did:
  - Glipizide, metformin, Levothyroxine on med list
  - Discussed diabetes and thyroid
  - Ordered A1c and TSH

Oops!
- A1c and TSH results done 2 weeks prior were identical
- Left adrenal mass on abdominal CT
Case 2 ("wasted days & wasted nights")

- 28 year old female had routine consultation appt booked with us by her PCP front office staff with cc/o “fatigue”
- No records sent
- 3 month wait

Oops!

- She has Lupus and needed Rheumatology consult, I’m an Endocrinologist....
- Now a 5 month wait....
Case 3 ("TMI-Overload")

- 74 year old woman with cognitive impairment from Skilled Nursing Facility brought in by transport person
- No records except MAR
- SNF physician on the road
- Look in the HIE....

- 94 pages of reports
- Diabetes
- Pituitary mass
- Osteoporosis

But what’s the question?
Any of these situations sound familiar?

Failures in care coordination are common and can create serious quality concerns.

Bodenheimer  NEJM 2008
Two Pronged Tale

My Practice Approach (living it)

- Difficult to give the kind of care my patients needed without the necessary records
- My front desk person was frustrated at lack of records
- Survey on Referrals to my practice: ~50% of the time:
  - No records/ no relevant data
  - No reason for referral stated
  - Missing basic data
  - Patient didn’t know why they had been referred

Policy Approach
Defining Expectations: the Care Coordination Agreement

• “One-on-one”-Compacts with selected Medical Neighbors
  – PCMH practice with specialist
  – ACO with a specialty

• System-wide “adoption” (all players with-in system)
  – Closed or Integrated systems (VA, SFGH, within ACO or IPA)

• Unilateral approach
  – Medical Center / Specialty Practice (“this is how we agree to work with those who refer to our center/practice and this what we would like from you when you refer a patient”)

MCPIPA Medical Neighbor Incentive:

Focus on the **Referral Process**:

- **Referral Request**
  - Clinical Question
  - Supporting data
- **Prepared Patient**
- **Referral Response**
  - Address Clinical Question

**Referral Tracking**

- Confirmation of appointment or decline (redirect) referral
- Notification of *No Show* or Cancellation
Referral Request Elements

Before & After CCA Referral Form

**Basic Data**

- Demographics
- Core data
- Med list
- Referral status

**Clinical Question/RfR**

- None
- Dx only
- Adequate

**Pertinent Data**

- None
- Partial
- Adequate
Aiming for The Right Care at the Right Time in the Right Place

• A referral is part of *taking care* of the patient
  – Meeting their needs

• “Working the Referral” helps meet those needs more appropriately
  – Triage and Tracking
  – Disposition
## Triage and Tracking

**Urgent**

**Move up**

**Routine**

**Short Call**

<table>
<thead>
<tr>
<th>Date Rec'd</th>
<th>Referral Reason</th>
<th>Triage</th>
<th>Insurance</th>
<th>Appt Date</th>
<th>Date Sched</th>
<th>Confirm Sent</th>
<th>Add Info Req</th>
<th>Add Info Rec</th>
<th>Pre-Consult</th>
<th>Note Sent</th>
<th>1st Attempt</th>
<th>2nd Attempt</th>
<th>3rd Attempt</th>
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<td>8/19/2015</td>
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<td>Medicare</td>
<td>11/11/2015</td>
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<td>&quot;canceled apt&quot;</td>
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<td>Routine</td>
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<td>Umbrella</td>
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<td>9/9/2015</td>
<td>Mass</td>
<td>Routine/Short Call</td>
<td>Medicare</td>
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<td>BCBS</td>
<td>11/18/2015- moved up to 9/10/2015</td>
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Average: 10/11/2015; Count: 450; Sum: 10/11/2015
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<thead>
<tr>
<th>First Name</th>
<th>Referral Reason</th>
<th>Appointment Date</th>
<th>New Appointment</th>
<th>Date Scheduled</th>
<th>Insurance</th>
<th>Notes</th>
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<tr>
<td>Cindy</td>
<td>Hyperparathyroid</td>
<td>Wednesday, February 24, 2016</td>
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<td>BCBS</td>
<td>Will call back about move up options</td>
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<tr>
<td>Debra</td>
<td>Hypogonadism</td>
<td>Tuesday, March 1, 2016</td>
<td></td>
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<td>Medicaid</td>
<td>Lives in Moab</td>
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<tr>
<td>Emily</td>
<td>T2DM</td>
<td>Wednesday, March 16, 2016</td>
<td></td>
<td></td>
<td>Medicaid</td>
<td>Appts after 1pm ... offered 11/10 @ 1:40pm she couldn't make it.</td>
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<tr>
<td>Tara</td>
<td>Pituitary</td>
<td>Tuesday, April 5, 2016</td>
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<td>Medicaid</td>
<td>Physician from China ... can call same day</td>
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<td>Margaret</td>
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<td>BCBS</td>
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<td>Chuck</td>
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<td></td>
<td>Medicare</td>
<td>only 1:40pm appts</td>
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<tr>
<td>Bruce</td>
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<td>Shirley</td>
<td>Hypothyroid</td>
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<td>RMHMO</td>
<td>Called 12/30 ... Having heart palpitations would like moved up</td>
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<td>James</td>
<td>Low Cortisol</td>
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<td>Medicaid</td>
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<td>Avon</td>
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<td>Tri Care</td>
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<td>Yayoi</td>
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<td>Fred</td>
<td>DM</td>
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<td>Brenda</td>
<td>DM</td>
<td>Thursday, April 7, 2016</td>
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<td>Hirutisim</td>
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<td>Moved up</td>
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<tr>
<td>Tina</td>
<td>hypothyroid</td>
<td>Wednesday, March 2, 2016</td>
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</tbody>
</table>
Pre-consultation/E-consultation
(to expedite and prioritize care)

• **Avoid unnecessary specialty visit**
  – Answer clinical question
  – Identify inappropriate referral

• **Expedite care**
  – Urgent cases

• **Referral guidelines**
  – Prepared patient
  – Utilize providers at the top of their license
Working the Referral-Disposition

• Pre-consult/ Redirect
  – Thyroglossal duct cyst
  – Rheumatology or other specialty disorders

• Pre-consult/ Avoid unnecessary appointment
  – Abnormal thyroid/other endocrine labs: ? Biotin
  – Small incidental thyroid nodule: guidelines

• Pre-consult/ Pre-visit Prep
  – W/u for adrenal incidental mass
  – Lab testing for abnormal menses/amenorrhea
  – CGMS testing for unexplained blood sugar results
  – Expedite Urgent evaluation/management (new onset T1DM or adrenal insufficiency)
Impact on Wait Times

Wait Time for New Patient Appointment (days)

Months since Initiation of E-referral

- Endocrinology
- Rheumatology
- Pulmonary
- Cardiology
- Nephrology

Courtesy E. Murphy MD SFGH
Many Benefits

- Reduce unnecessary testing
- Reduce unnecessary consult / office visits
- Open up clinic spots for sicker patients (access)
  - Reduce harm/ effects of illness
  - Reduce ED and Hospital utilization
- Reduce travel and time off of work
- Enhancement of “learning system”
- Better Care for the Patients
- Enhance relationships and working together
  - Comradery, nurturing, satisfaction & joy
- Creating a “system of care”
It’s not about trying harder.....

• IOM Crossing the Quality Chasm
  – “…the effective remedy is not to browbeat the health care workforce by asking them to try harder …. If we want safer, higher-quality care, we will need to have redesigned systems of care...[and]... ongoing tracking to assess progress…”

(the definition of insanity is doing something the same way and expecting a different outcome)

• trans·form
  verb \tran(t)s-ˈfȯrm\ : to change (something) completely and usually in a good way
Turning Good Intentions into Good Results

• UMA data 27%
• Trying harder – Increased to 37%
• Team Care – Increased to 93%
It Takes a Patient-Centered Team

• Huddle work
  – The broken record ("We are a team, your job is to take care of our patients. Your role on the team is... but your job is taking care of the patients")
  • Changing from task work to team care
  – The Why...connecting staff to the care (it’s about the patient)

• Scheduling for team care
  – Added 20 min for team care to each appt (as a hidden “under-lap” on schedule)

• Policies & Procedures (making it official)

• Working the Registry (getting it done)

Good intentions built into the appointment instead of lost in the appointment
A place where everyone knows your name

“I’ll download your glucose meter or pump”

“You know what you need to do, shoes off and here is the cup!”

Anything you want to work on? Are you having a hard time with anything?”

“This is not a courthouse. We are not judges. Our job is to help you live with the diabetes.”
The Voice of the Patient

• “I feel much better about myself now”
• “I feel in control of the diabetes, instead of it being in control of me”
• “No one had ever taken the time to explain things to me before, now I understand and that makes a big difference.”
• “I feel confident and safe.”
• “I like that things are looked after for me.”
“The Transformation Journey”

• Acute care model
  – Staccato care
  – ER model

• Physician centered
  – Physician carries the load & responsibility
  – Staff supports physician

• Silos of care
  – Separated care providers
  – Disconnected care

• Chronic Care Model
  – Care that is Comprehensive, continuous & coordinated

• Patient-Centered Team Care
  – Shared accountability for what is best for the patient

• Medical Neighborhood-System of Care
  – Connected, coordinated care

The Right Care at the Right Time in the Right Place
What does transformation have to do with it?

**QPP**

“If you’ve been doing PQRS/ MU, you will be fine”

“Don’t worry, we will take care of everything for you”

**TCPi**

Change !#!
Attention
Time
Re-working
New Processes
Expectations
We are going to pay you based on **HOW WELL** you provide care, instead of just **HOW MUCH** you do.

We have support to help you improve & prove **HOW WELL** you provide care.
Carrots and Sticks

Pick Your Pace in MIPS
If you choose the MIPS path of the Quality Payment Program, you have three options.

- Don’t Participate
- Submit Something
- Submit a Partial Year
- Submit a Full Year

2017 MIPS Performance

- Quality (60%)
- Advancing Care Information (25%)
- Improvement Activities (15%)

https://qpp.cms.gov/
# Compare Performance Evaluation to Benchmarks

## Table 1: Using Data in Benchmark to Estimate Points (For Non-Inverse Measures)*

<table>
<thead>
<tr>
<th>Decile</th>
<th>Number of Points Assigned for the 2017 MIPS Performance Period</th>
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<tbody>
<tr>
<td>Below Decile 3</td>
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<tr>
<td>Decile 3</td>
<td>3-3.9 points</td>
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<td>Decile 4</td>
<td>4-4.9 points</td>
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<td>Decile 5</td>
<td>5-5.9 points</td>
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<tr>
<td>Decile 6</td>
<td>6-6.9 points</td>
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<td>Decile 7</td>
<td>7-7.9 points</td>
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<td>Decile 8</td>
<td>8-8.9 points</td>
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<td>Decile 9</td>
<td>9-9.9 points</td>
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<tr>
<td>Decile 10</td>
<td>10 points</td>
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*For inverse measures, the order would be reversed. Where Decile 1 starts with the highest value and decile 10 has the lowest value.*
Points will depend on performance data submitted.
If your performance was 90.14, the practice would receive 5.9 points.
CMS Framework for Advancing VBP

Think “Taking it in Steps”

Category 1: Fee for Service – No Link to Value
  • Pure FFS

Category 2: Fee for Service – Link to Quality
  Category 2a • Pay for Reporting
  Category 2b • Pay for Performance

Category 3: Alternative Payment Models Built on Fee-for-Service Architecture
  Category 3a • APMs w/ upside risk
  Category 3b • APMs w/ downside & upside risk

Category 4: Population-Based Payment
  • Population-Based Payment

“get house in order”

It is not just reporting...

• Need to achieve higher VALUE
  – Improved outcomes
  – Reduced costs

...And need a way to do that
It’s not about trying harder.....

It’s not about doing more...

It is about doing it in a new way

**transformation:**

a thorough or dramatic change
What Happened?

Poorly Designed EHRs

- E-Prescribing benefit
  - Designed for billing/auditing format not clinical workflow
  - Outdated, cumbersome, time consuming “logic pathways”
    - 34 clicks to document a flu shot
  - >50% of work time spent on EHR
    - ~ 27% with face-to-face direct patient care
    - For every 1 hour of face-to-face care spend 2+hours on EHR
    - Workforce misutilization
- Blockade of interoperability

“the new mindlessness” (loss of meaning)…
What happened?:

Overuse/Misuse of measures & “lean”

- Mountain Range of Metrics
- ...mismatched attributions
- Misapplication of “QI” methods... like a Machine ...loss of adaptability & resiliency

QI became a 4 letter word
What happened:

2017 report:

- >51% of physicians
  - 4+ out of 7 on burn out severity scale
    - Bureaucratic tasks
    - Too much time at work
    - Feel like cog in wheel

- Effects on Care Delivery
  - Increased errors
  - Decreased patient adherence & satisfaction
  - Loss of purpose in work
  - Loss of motivation for job
  - Loss of work force
The bottom line...

Even before Payment Reform we needed a better system...for our patients *and for our care providers*

But now we **have** Payment Reform...

- Medicare
  - QPP -MIPS
  - Medicare Alternative Payment Models - ACOs
  - Bundled Payments
- Medicaid & Commercial Payers
  - *Value Based Payment (VBP)* models

*...We need to deliver care differently*
Transforming Clinical Practice Initiative

Vision:
Provide transformation support to 140,000 clinicians to achieve the *quadruple aim* and improve care for millions while reducing per capita costs through reduced hospitalizations and readmissions; avoidable ED visits, and unnecessary testing

Goal:
Prepare providers for *value-based compensation models*
Now for the patients we see...

- Our payments will reflect the “Value” of the care

- Value = Quality (Benefit)/Cost
  - Quality = patient outcomes
  - Cost = Resource use (with emphasis on reducing unnecessary care)

Need to ensure patients get the care they need...and reduce care that adds no benefit...

...and do it in a way that improves practice satisfaction & joy for those providing the care
It is about a *new* approach...

* Using **practice data** to measure how we are doing
  * Using data as information about care *(as an indicator)*
  * Actionable and meaningful...there needs to be a “WHY”

* Having a **method** to make the improvements
  * Include entire staff/team in the process
  * Having Aims or Goals
  * Culture of continuous improvement

* Working as a **team**
  * To make the changes (transformation team) (how to do it at the clinic level)
  * To provide care (care team) (shared accountability)

* “Re-centering” for patient-centered care *(partnership)*
  * Enhanced Patient & Family Engagement in care

* Improving **care coordination & communication**
  * Improving access-Connecting care
Redesign...

• Rather than being an organizational construct,

• Redesign refers to a **new perspective** on
  – the **purpose and aims** of the health care system,
  – how **patients and their clinicians** should **relate**, and
  – how care **processes can be designed to optimize responsiveness** to patient needs
“The gap between vision and current reality is also a source of energy.

If there were no gap, there would be no need for any action to move towards the vision.”

Peter Senge
Questions / Reflections
Improve constantly and forever... Deming

Becoming better is not a destination, it is a spirit of continuous improvement.

When you’re finished Changing... You’re Finished. Ben Franklin