ACHIEVING THE TRIPLE AIM THROUGH LARGE SCALE IMPROVEMENT EFFORTS

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TEACHERS OF QUALITY ACADEMY

QI SYMPOSIUM

MARCH 2, 2016

OVERVIEW: WHAT, WHO, HOW?

What: How do you move a large multi-specialty organization toward achieving the Triple Aim of Better Care, Better Health, and Reduced Costs?

Who: People of Eastern North Carolina – managed by ECU Physicians

How: Identify the problem, set a goal, follow your guiding principles, utilize QI processes best suited for each problem

OVERVIEW: WHAT, WHO, HOW?

- Goals taken from IHI Triple Aim
- Driven by ECUP Core Purpose/Values/Envisioned Future
- Current initiatives *(small snapshot of many ongoing projects)*
  - Utilization Improvement (Better Care)
  - Quality Improvement (Better Health)
  - Coordination of Care (Reduced Costs)

"Today we are primarily in the business of delivering care one patient at a time. By contrast, a population health practitioner is concerned with achieving healthy outcomes for an entire population."

—Steven Lefar, Sg2 President and CEO

GOALS: SEARCH OF THE QUADRUPLE AIM (TRIPLE AIM +1)

What do we want?

Patient Centered Care that promotes:

Better Care, Better Health, and Reduced Costs while creating an environment that promotes team work and resiliency for our care teams

ECUP CORE PURPOSE, VALUE, AND ENVISIONED FUTURE: OUR GUIDING PRINCIPLES

Core Purpose:

To provide the highest quality and most compassionate healthcare to the people of eastern North Carolina while educating the next generation of health professionals to do the same

ECUP CORE VALUES

For Our Patients

*We will provide **timely access** to patient-centered health services of the highest value.*

For Our Community and Partners

*We will **continuously improve** our clinical services and systems.*

For Our Learners

*We will **cultivate a clinical environment** of robust learning, innovation and discovery.*

For Our Team

*We will **empower each other** to **pursue passions** that improve the care and experience for our patients.*

For Our University

We will generate sustaining resources in support of the Brody School of Medicine.

ECUP ENVISIONED FUTURE

We envision a future in which the people of eastern North Carolina consider ECU Physicians to be their **most trusted choice** for health care. Thus, our constant focus will be on providing world class care characterized by:

1) health services of the **highest quality**
2) **guaranteed access** to those services when our patients need and want them
3) continuous **enhancement of the value** of those services.

Our world class care will be distinguished by a **robust primary care network** and **patient-centered medical home** that promotes close and constant coordination with our specialists and regional partners.

BETTER CARE: UTILIZATION IMPROVEMENT

- **Problem:** Need to improve access to care for primary and specialty care
- Access Improvement Working Group formed July 2015
- Process Improvement Solution:
  - Project Charter
  - Fishbone Analysis
  - Specific Aim statement
  - Measures of success

BETTER CARE: UTILIZATION IMPROVEMENT

Project Charter for: Access Improvement Working Group

V2. 9.21.15

Problem Statement: Keeping with the revised ECU Physicians Core Values/Purpose document, our strategic direction is to provide timely access to patient–centered health services of the highest value and we envision a future in which our patients have guaranteed access to those services when our patients need and want them.

Currently, access to establish care in primary care is limited and wait times for certain specialty clinics are longer than desired.

Aim Statement:

Increase Access to Primary Care (while maintaining continuity)

1. Same day or next day engagement for new and returning patients, contingent on their needs and preferences

Increase Access to Specialty Care

1. Third next available waits of 10 days or less for new visits. For specialty care visits accompanied by greater sense of patient urgency, waits no more than 1 day for new patients.

Goal completion rate by December 31, 2016

Measures of Success:

Success will be noted if the time to 3rd next available for primary care will be < 1 week (5 days) and time for established care appointment to primary care will be < 2 weeks.

All specialty care new referrals will be seen within 10 days.

BETTER CARE: UTILIZATION IMPROVEMENT

Scope:

- All ECU Physicians Clinics:
  Primary Care: FMC, Firetower, IMC, APHC, Peds,
  Specialty Care: OB/GYN, ENDO, DERM, CARDS, NEURO, ID

Boundaries:

-Ensuring adequate supply of appointments to meet demand

-high no show rate decreasing appointment utilization

Start date: 9/1/15

End date: 12/31/16

Sponsor: ECU Physicians MOT

Other Sponsors:

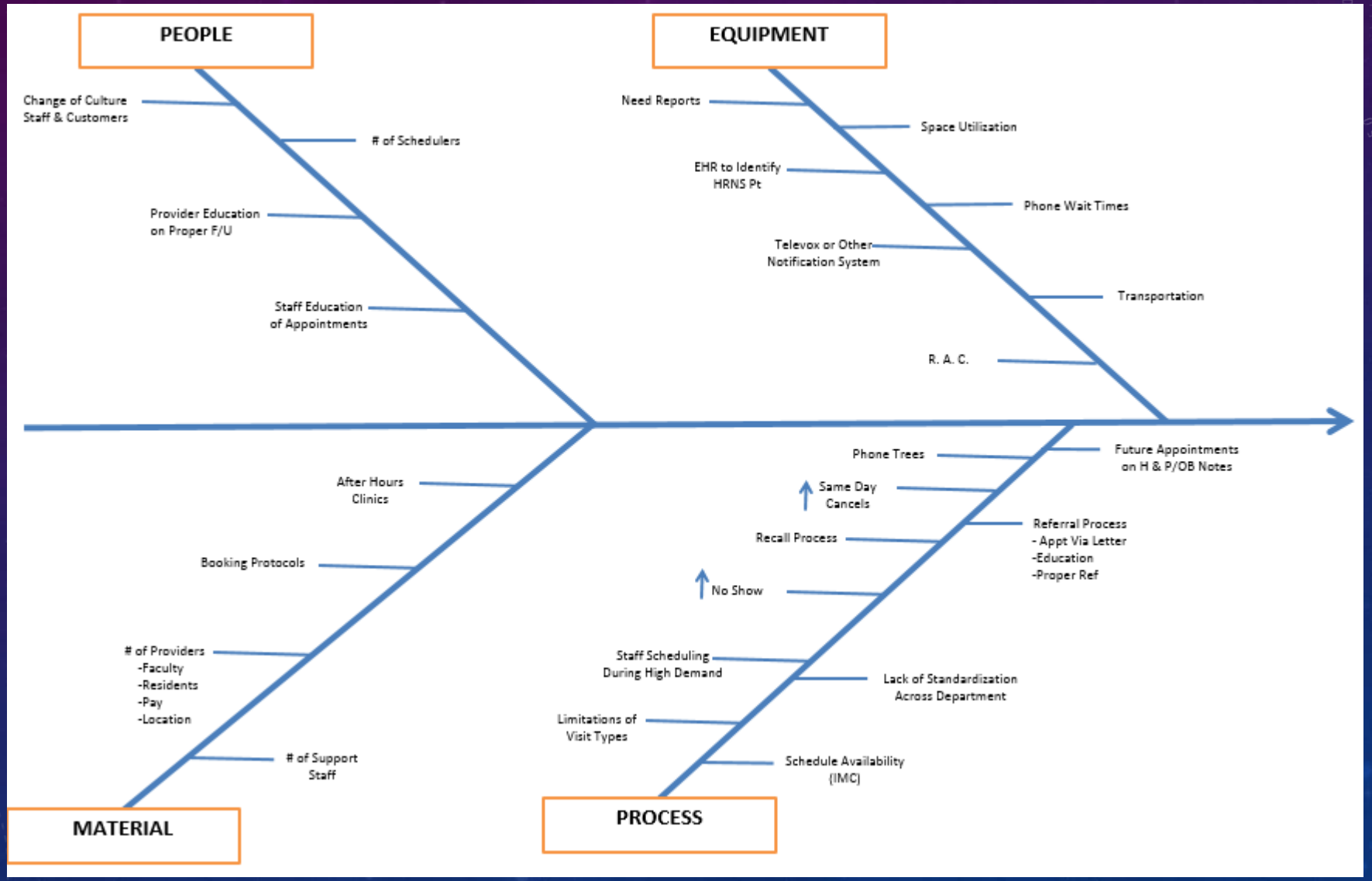
Dagmar Herrmann-Estes, Director Clinical Finance and Support Services

Facilitators: Jason Foltz – Associate Medical Director ECU P

Team Members:

1. Bob LaGesse-COE
2. Denethia Platt- PAS specialty care
3. Michelle Edmundson—CFS Training Manager and Interim CFS PAS Manager
4. Nicole Cox – CFS Report Writer
5. Martha Dartt- Director of Nursing
6. Caroline Houston – Specialist Physician

BETTER CARE: UTILIZATION IMPROVEMENT



BETTER CARE: UTILIZATION IMPROVEMENT

Baseline Data (3rd Next available): Snapshot

Primary Care	Jul	Aug	Sep	Oct	Nov	Dec
APHC	8	9	11	8	10	11
FM Purple	12	14	17	11	9	11
FM Gold	6	9	11	9	10	11
FM Buccaneer	8	10	8	7	12	9
FM Pirate	6	6	6	5	12	8
GIM Resident	18	14	16	20	19	30
GIM	2	5	5	4	3	2
FM Geriatrics	19	23	8	17	21	17
FM Firetower	3	2	1	3	8	6
OBGYN Faculty	16	4	15	11	4	3
Peds Private	3	11	2	7	7	1
Peds Adolescent	1	0	0	1	0	0
Peds Continuity	10	11	6	7	7	6
Peds Comprehensive	20	11	2	2	1	3
Median Average PCP	**8**	**9**	**7**	**7**	**9**	**7**
Median Average Peds	**7**	**11**	**2**	**4**	**4**	**2**
Median Adult PCP	**8**	**9**	**9**	**9**	**10**	**10**

BETTER CARE: UTILIZATION IMPROVEMENT

Challenges:

- Obtaining data (3rd next available, utilization %) - #1,#2,#3!!
- Reasons for reduced access different across system:
  - Lack of demand
  - Lack of appointment standards
  - Lack of supply
  - Lack of space

Next Steps:

- Continued optimization of data
- Targeted LEAN interventions at clinics identified as having limited access

BETTER HEALTH: IMPROVED QUALITY METRICS

- **Problem:** Potential Reimbursement cuts related to performance measures from CMS
- Formed Quality Work Group July 2015
- Process Improvement Solution:
  - Review of baseline data
  - Goal setting
  - Monthly PDSA cycles
    - Team education
    - Workflow education
    - Monthly Feedback
    - Physician Leadership

BETTER HEALTH: IMPROVED QUALITY METRICS

- Developed ECUP Quality Spotlight (Based on PQRS data):
  - Colon Cancer Screening
  - Diabetic Foot Exams
  - A1c Control

BETTER HEALTH: IMPROVED QUALITY METRICS

ECUP Quality Spotlight - CY 4Q 2015 Measures

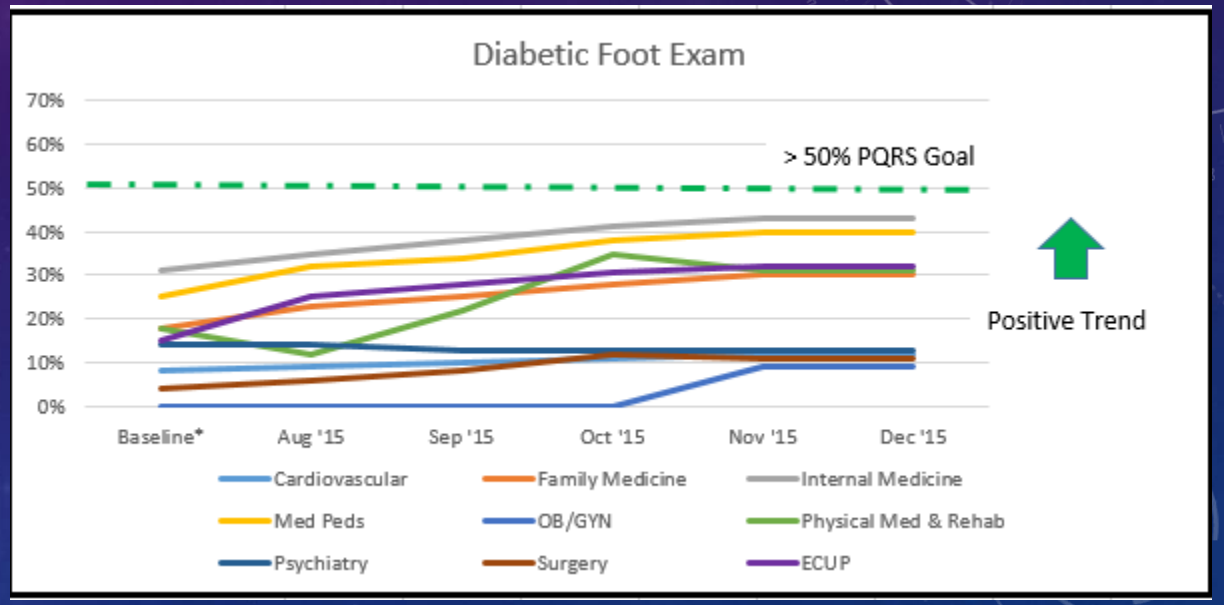
Diabetic Foot Exam

The goal is to increase the % of ECUP patients aged 18-75 with diabetes who had a foot exam during the last 12 months.

Department	PQRS Goal	ECUP Goal	Baseline *	Measure Period** Aug '15	Sep '15	Oct '15	Nov '15	Dec '15
Cardiovascular	> 50%	> 80%	8%	9%	10%	11%	12%	12%
Family Medicine	> 50%	> 80%	18%	23%	25%	28%	30%	30%
Internal Medicine	> 50%	> 80%	31%	35%	38%	41%	43%	43%
Med Peds	> 50%	> 80%	25%	32%	34%	38%	40%	40%
OB/GYN	> 50%	> 80%	0%	0%	0%	0%	9%	9%
Physical Med & Rehab	> 50%	> 80%	18%	12%	22%	35%	31%	31%
Psychiatry	> 50%	> 80%	14%	14%	13%	13%	13%	13%
Surgery	> 50%	> 80%	4%	6%	8%	12%	11%	11%
ECUP	> 50%	> 80%	15%	25%	28%	31%	32%	32%

* Baseline - April '15-July '15

** Cumulative April thru end of month shown



BETTER HEALTH: IMPROVED QUALITY METRICS

Challenges:

- Understanding data sources
- Creating Culture of Medical Neighborhood
- Education on the importance of the measures
- Standardized documentation
- Team buy in
- Communication
- Time

Next Steps:

- Continued education/optimization of EHR tools and workflows
- Continued roll out of additional quality spotlight measures related to ACO

REDUCED COSTS: CARE COORDINATION

- **Problem:** How to move to proactive care coordination in a fee for service world? How to meet NCQA population health standards? How to utilize Medicare 2015 Chronic Care Management Codes?
- Traditional RN position description rewritten to include Care Coordinator (50%) July 2015
- Process Improvement Solution:
  - Identify high risk population – Medicare Patients
  - Begin proactive interventions – based off of Chronic Care Management Code Criteria

REDUCED COSTS: CARE COORDINATION

Identification of High Risk Patients:

- Initial list run of FMC Medicare patients = 284 HR patients (July 2015)
  - eBIC report- Claims data, Dx of DM/HTN, Medicare pts, ED visits of >4 in 12 months
- Additional report run from EPIC using ambulatory high risk assessment score for Medicare = 30 additional HR patients (Sept 2015)
  - No PCP, Age > 75, Single, Polypharmacy, incr problem list, ED visits, Payor, Depression, prior Drug use
  - 5 or more = High Risk
- PCP self referral

REDUCED COSTS: CARE COORDINATION

Proactive interventions:

- All patients sent a letter inviting them to participate in Chronic Care Management Program
- All patients called to explain program
- Consent, Patient Centered Care plan established
- Monthly calls established – focus on med rec, closing quality care caps, facilitating health needs, coaching related to care goals.

REDUCED COSTS: CARE COORDINATION

Results:

- Aug 2015 – Jan 2016:
  - 28/311 signed up = 9%
  - 33 claims submitted
- Patients have a single point of contact for the clinic
- Patient goals are documented to allow all team members to work toward them
- Additional referrals to ancillary services (nutrition, pharmacy, behavior medicine)

Barriers:

- Patients not wanting to accept monthly co-pay
- Patients feeling they have too many things going on vs. focusing on themselves

REDUCED COSTS: CARE COORDINATION

Next Steps:

- Begin monthly HR reports using EPIC High Risk patient report based on patient visits to FMC in last month
- Future look back on signed up patients tracking their healthcare system utilization
- Implement Advanced Care Planning discussions and Annual Wellness Exams
- Work collaboratively with our community partners to expand the program
  - Future collaboration with nursing school?
  - VH grant

COLLABORATIVE TEAM MEMBERS

Better Care: Bob LaGesse, Martha Dartt, Denethia Platt, Michelle Edmundson, Nicole Cox, Caroline Houston, Dagmar Herrmann-Estes

Better Health: Drillious Gay, Nicholas Benson, Tommy Ellis, Paul Bolin, Bob LaGesse, Martha Dartt, Andrew Anderson

Reduced Costs: Brittany Nicholson, Alyssa Adams, Jennifer Blizzard

LESSONS LEARNED

- Identify the problem
- Set clear goals and strategic direction
- Develop a clear communication and education plan
- Empower your team to work together at their highest levels
- Physician Leadership at all levels
- Feedback on performance (data driven improvement)
- Strive for excellence
- Investment in growth of our teams
- Collaboration with our partners

SUMMARY

Focus, dedication of resources, and continued collaboration will lead to a bright future for transformation of our healthcare system and overall health of the patients we serve!