Care of the Complex Patient

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EVP, Clinical Operations

Value-Driven Care for Complex Patients

- Value-based productivity measurement (Value-based RVUs??)
  - Care Gap Closure value per unit time
  - Low-value utilization ratio
    - Regular care "failures" (e.g., heart failure exacerbations)
    - Low-value resource consumption (e.g., low-utility imaging)
- Reengineered care processes
  - Use of EHRs, analytics and decision support (Eliminate Automate, Delegate, Activate)
- Health Care Teams, Accountable Collaboration
  - Medical Home, Primary care – specialist collaboration
- Cross-spectrum concerns
  - End-of-Live and Palliative Care
  - Medication management
- Fundamentally realigned reimbursement incentives

Care of the Complex Patient

Care Gap Management

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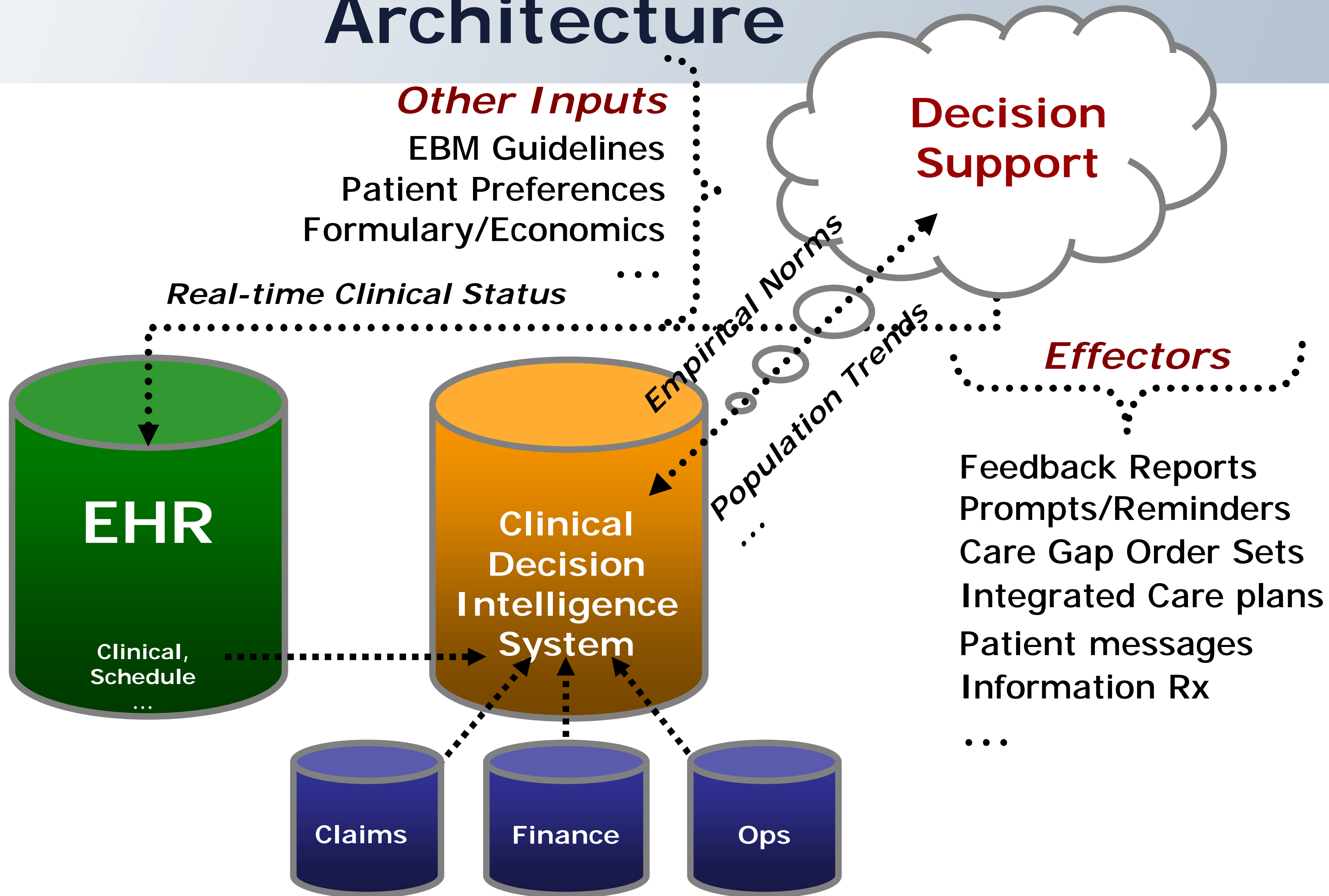
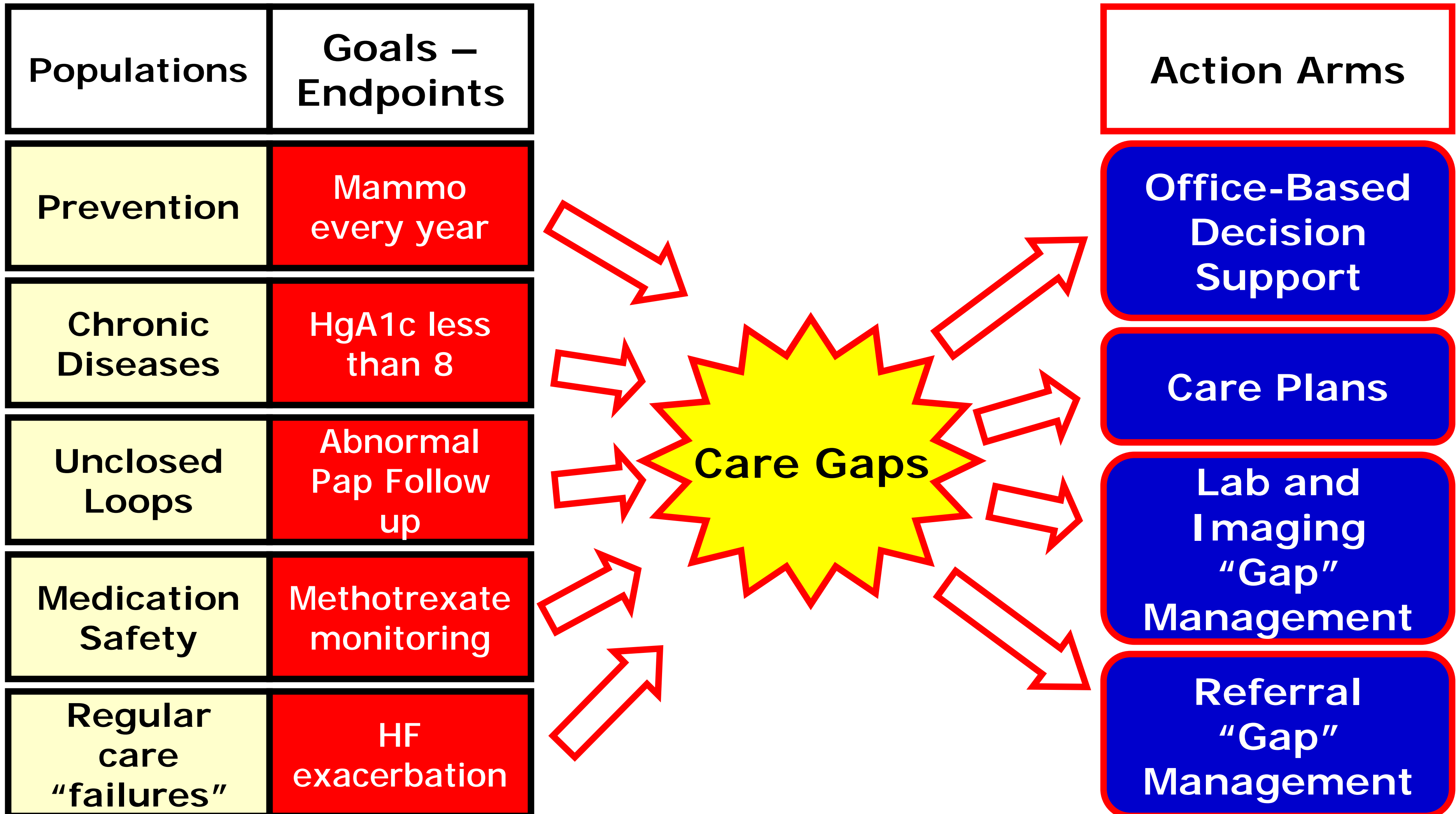
Care Gaps

- Patients, based upon their age, gender , chronic conditions, etc. , have predictable, evidence-based lab, imaging, medication and referral care needs
- Patients who fail to have their evidence-based care needs met have a "Care Gap"
- Complex, chronically ill patients are at high-risk for unclosed Care Gaps
- Traditional health care workflows are inefficient and unreliable at closing Care Gaps
- It is possible to reengineer care to increase both reliability and efficiency with which Care Gaps are closed
  - Requires IT and analytic infrastructure…

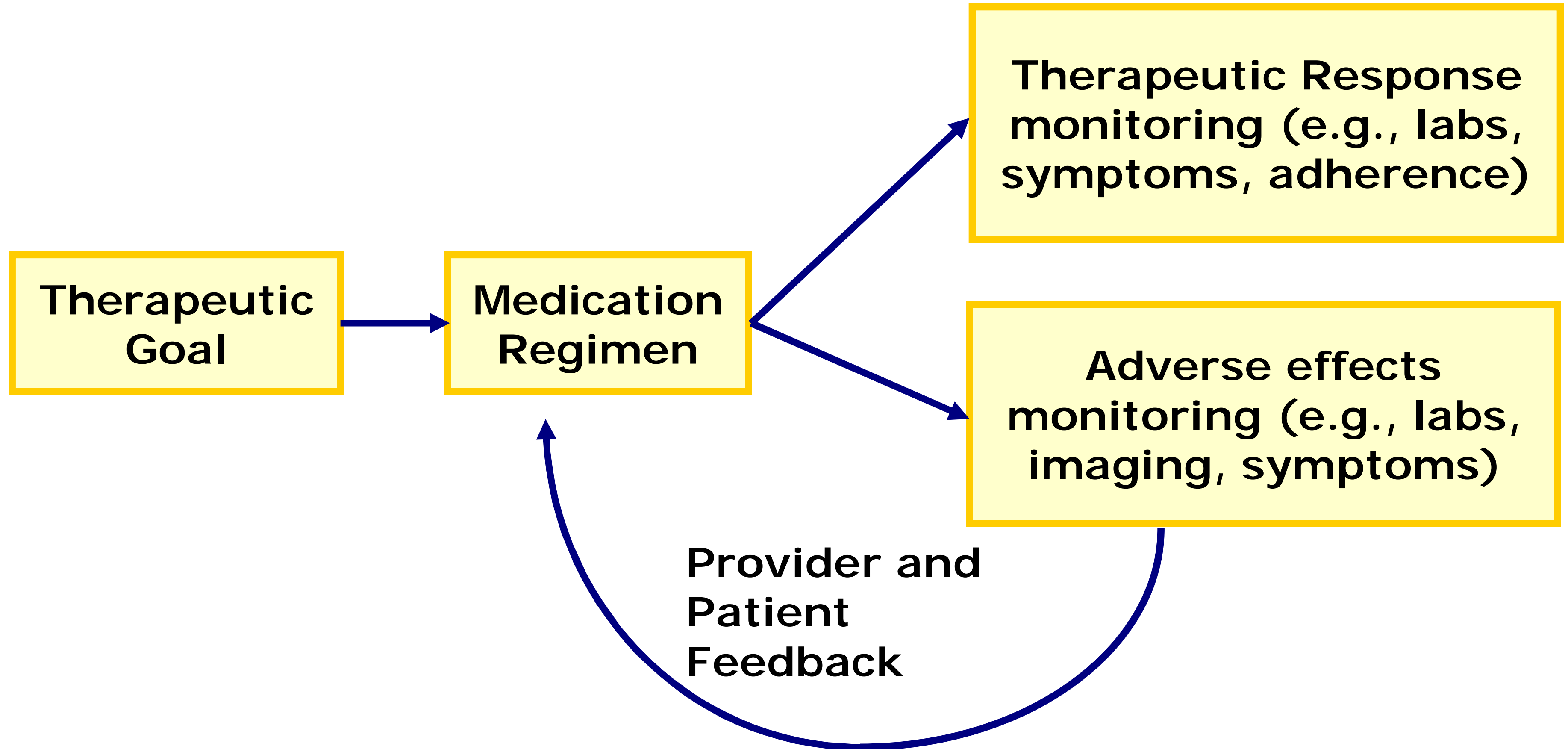
Geisinger Transformation Architecture



Care Gaps and Action Arms



Medication Management



Integrated Care Gap Order Sets

BestPractice Alerts

Hx of CAD. Consider aspirin, unless contraindicated.
☑ Open SmartSet: CAD ASPIRIN ORDER #3392

Medical Home Patient: Active Case Management

Dx of CAD and comorbid condition(s) - DM, HTN, CKD, and/or LVSD. Consider ACE/ARB therapy.
Jump to Order Entry

Dx of DM. HgbA1C less than 7.0% is standard.
Last HGBA1C=7.1 on 3/30/2009
☑ Open SmartSet: BP ALERT: DM HGBA1C 3 MONTHS #3175
Jump to Diabetes Management Report

Refresh   Accept

- Clinical Care Gaps that require medical decision making
  - Medication management
  - Chronic condition not at goal

Care of the Complex Patient

Primary Care – Specialty Collaboration

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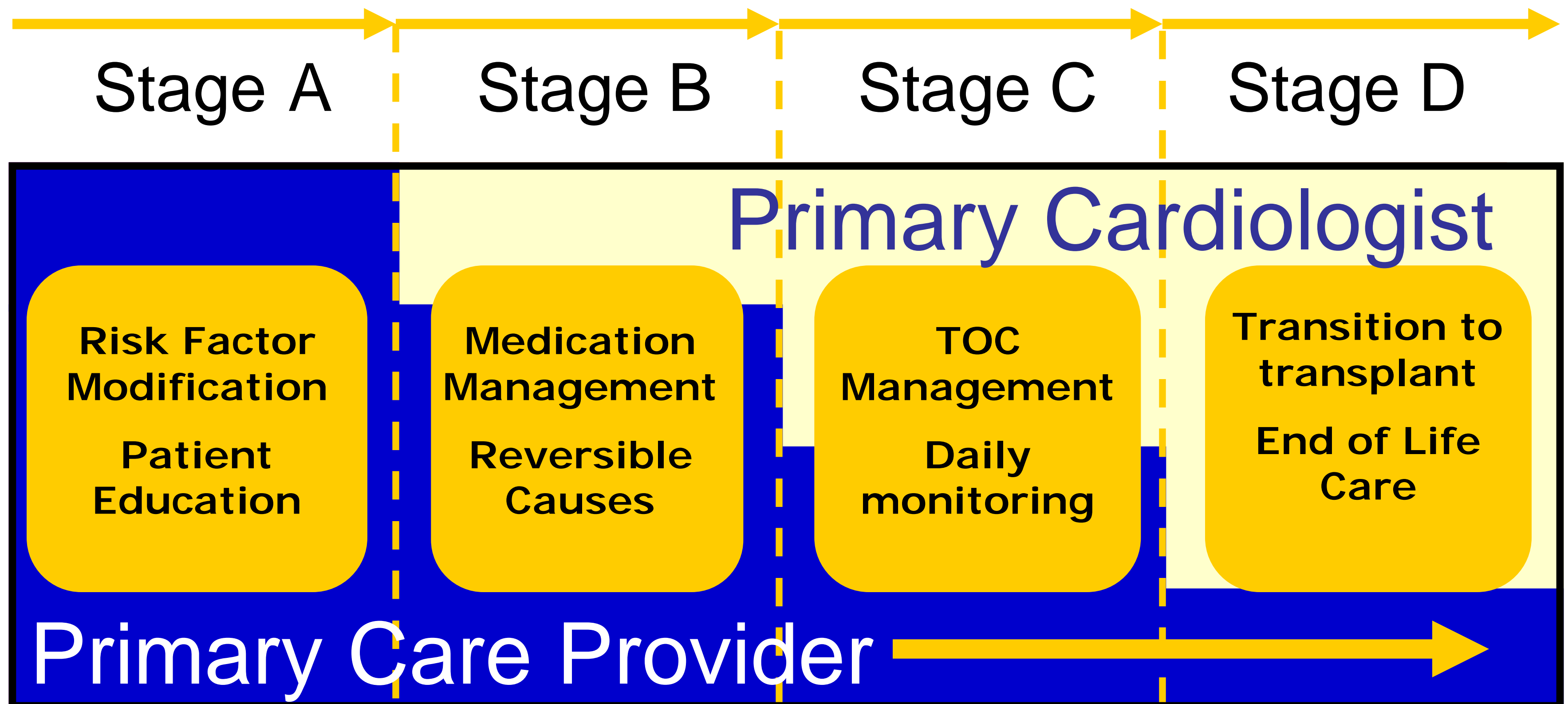
Primary Care, Primary Specialist and Collaborative Care

- Certain severely chronically ill patients require ongoing collaborative care by both a primary care and specialist provider
- In order to successfully co-manage care, expectations and roles need to be clarified including identifying the specific involved specialist and who is accountable (Primary Care vs. Specialty Care) for what aspects of care
- Ultimately, the goal of collaborative is to ensure that all care needs are managed and care gaps closed
- Patients needing ongoing co-management feel that the health care team is coordinated and collaborative

Conditions, Care Gaps and Potential Specialty Engagement

Condition or Care Gap	Specialty
CKD Stage 4	Nephrology
HTN > 140/90, 3 or more meds	Nephrology
AAA > 4 cm	Vascular
Carotid stenosis > 60%	Vascular
Persistent HgA1c > 9	Endocrine
Recurrent Asthma exacerbation	Allergy/Pulmonology
LDL > goal, statin allergy	Cardiology
Afib, > 2 CHADS no anticoag	Cardiology
Recurrent HF exacerbation	Cardiology
50 and over w fx of hip and spine	Rheumatology/HiROC
Melanoma	Dermatology
Rheumatoid Arthritis	Rheumatology

Heart Failure "Care Path"



Geisinger Examples

Creating Real Value: Geisinger's Core Care Transformation Initiatives

- Get consumers into a system of care, focused on the right things....
  - ...Medical Home
  - ProvenHealth Navi...
  - Chronic Di...
- Optimize the delivery of high-cost, high capital care
  - ...Acute® (...")
- Transitions...
  - Minimize hand-off errors, reduce wasteful end-of-life spending and degradation
- Get consumers and families involved, with personal responsibility
  - ProvenEn... ...mpliance"

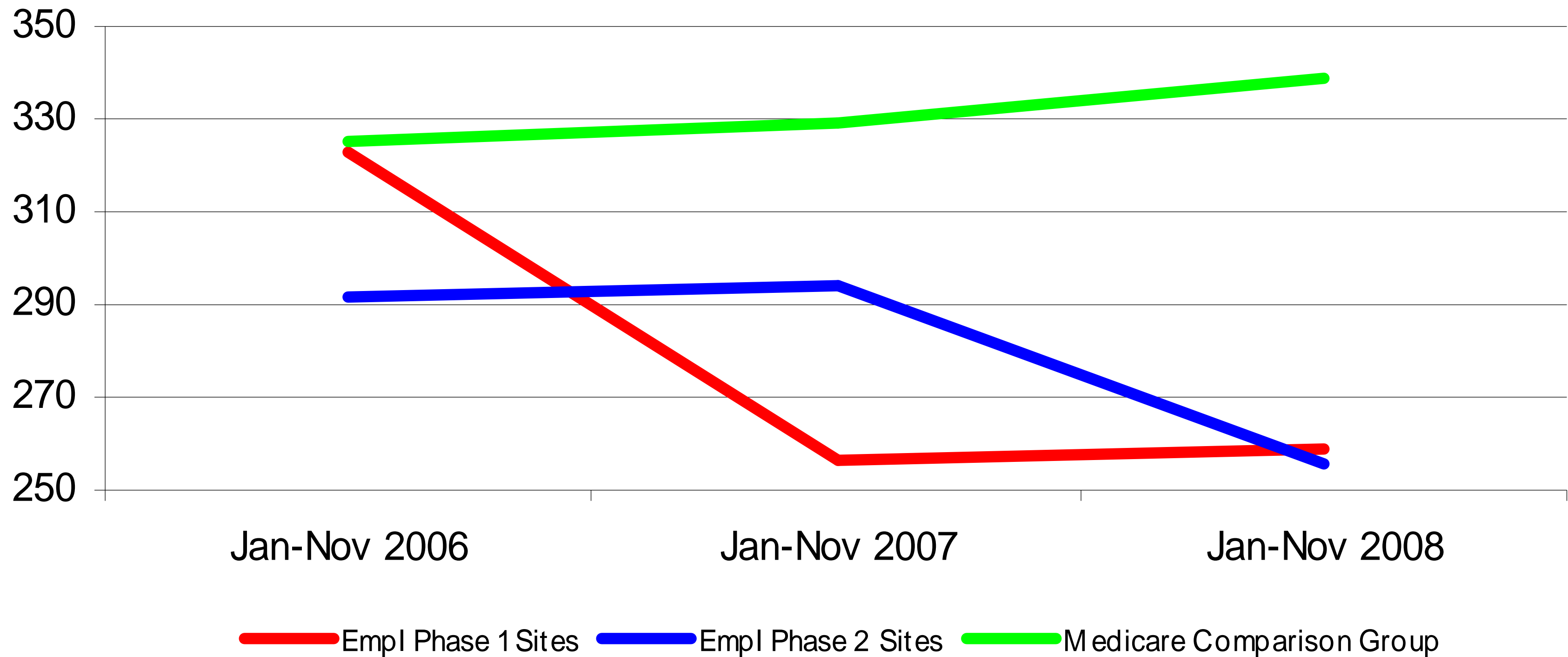
ProvenHealth Navigator®

Geisinger's Value-based
Patient-Centered Medical Home

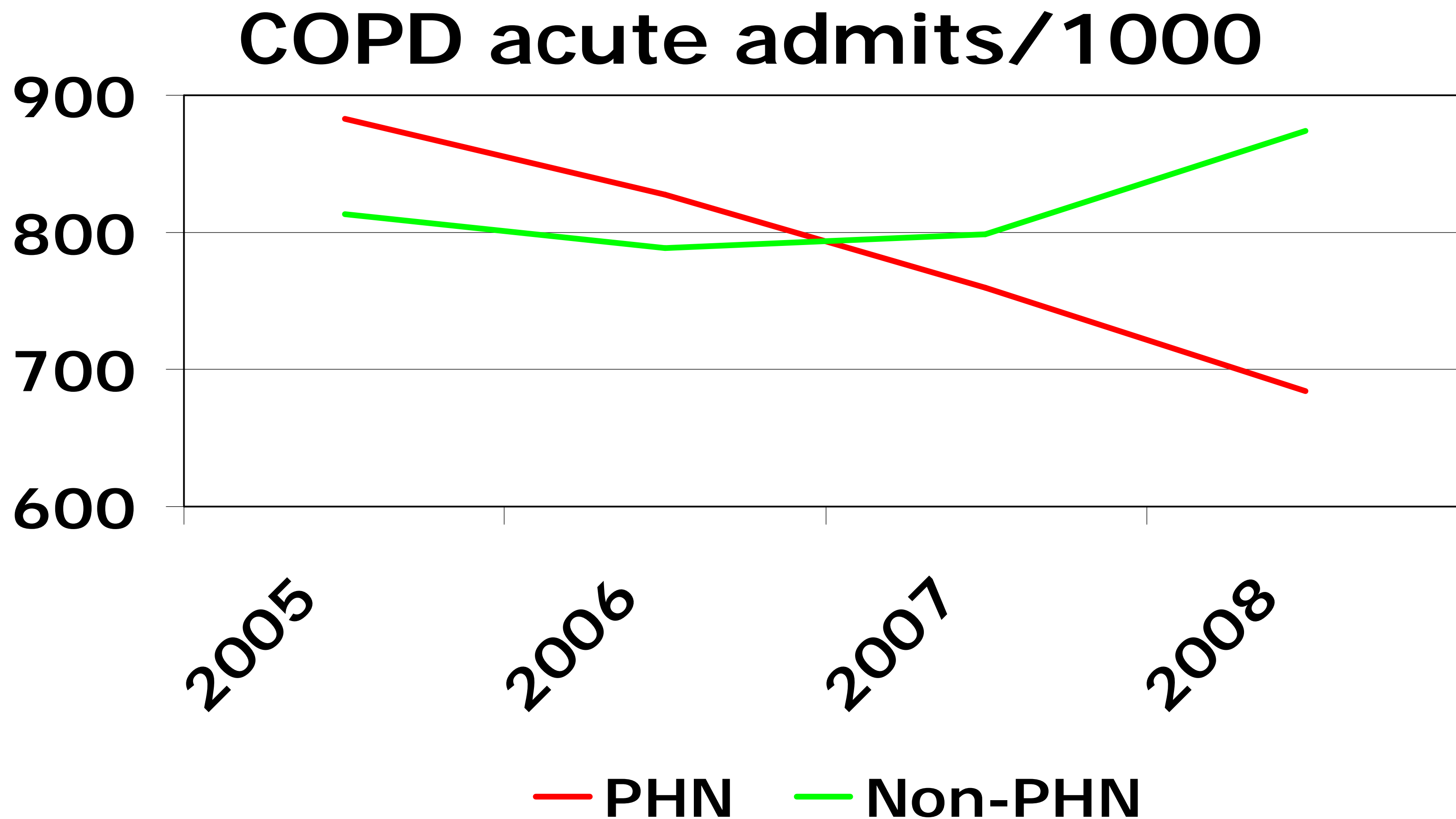
Functional Components

1. Team-based, patient-centered primary care (including embedded care management nurse)
2. Joint payor-provider population management
3. High quality, efficient specialist identification and referral
4. Quality Outcomes Program
5. Value-based Reimbursement Program
    1. Baseline FFS
    2. Practice transformation stipends
    3. Quality-gated gain sharing

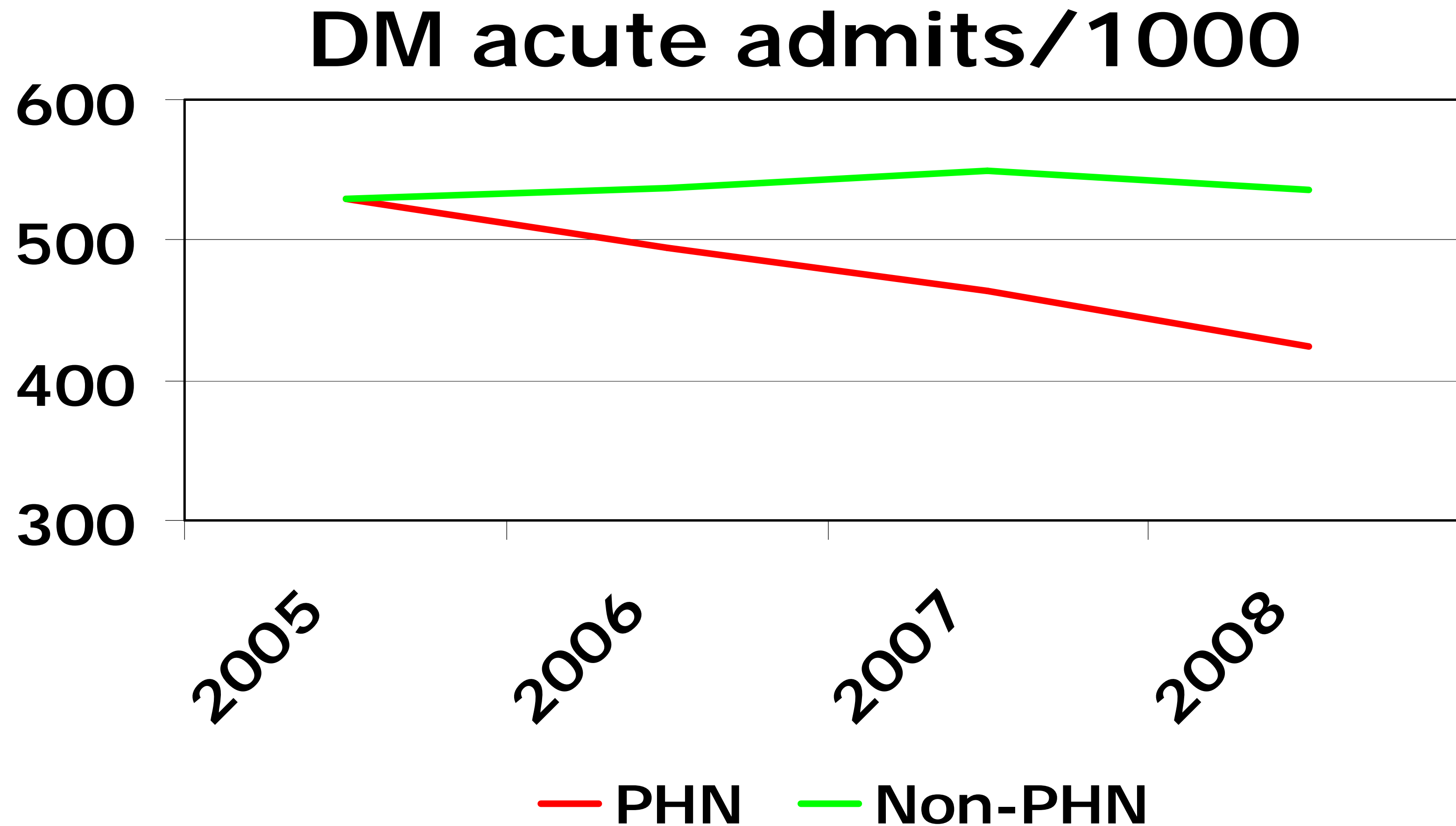
Inpatient Admission Reduction



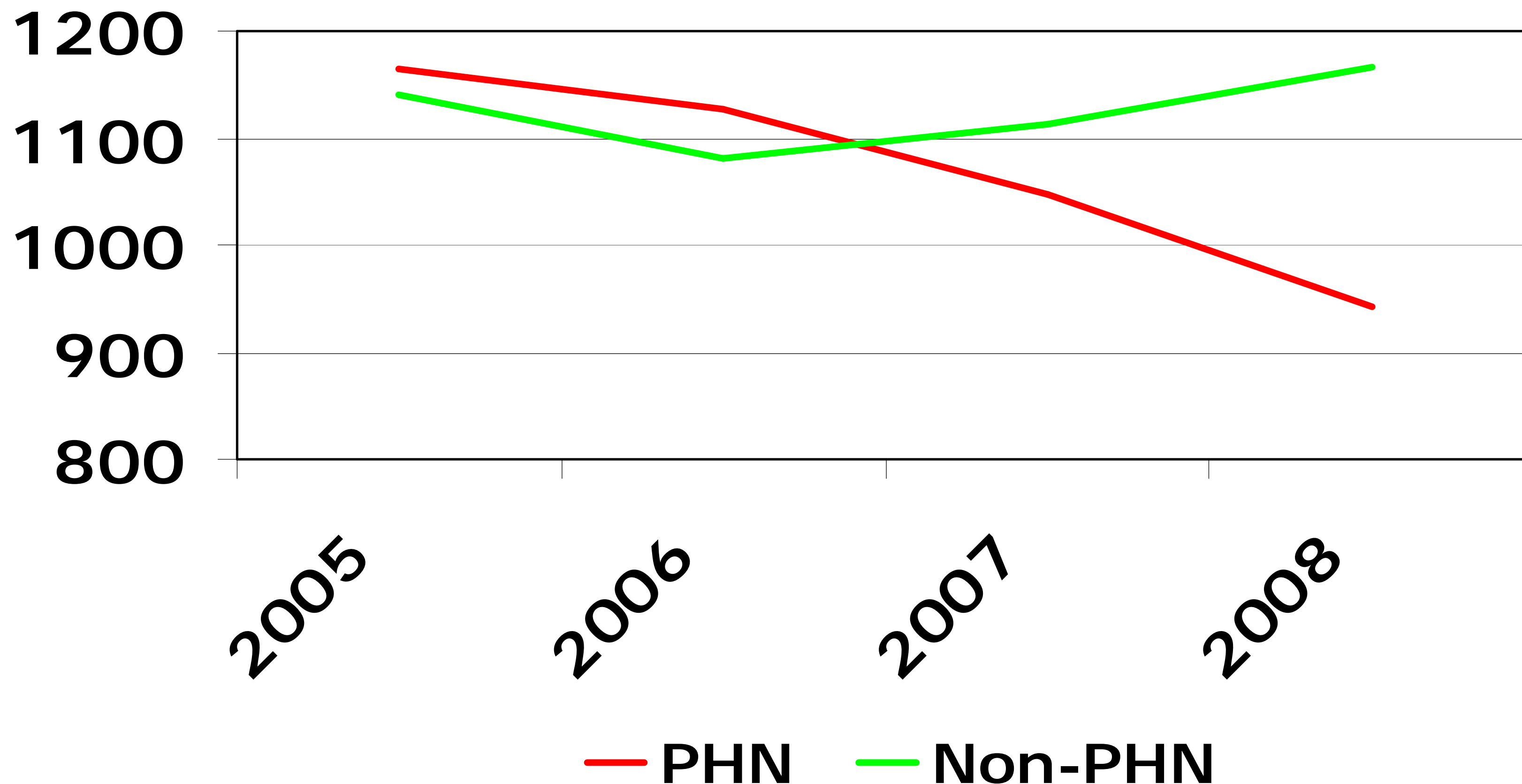
Impact: COPD Admissions



Impact: Diabetes Admissions



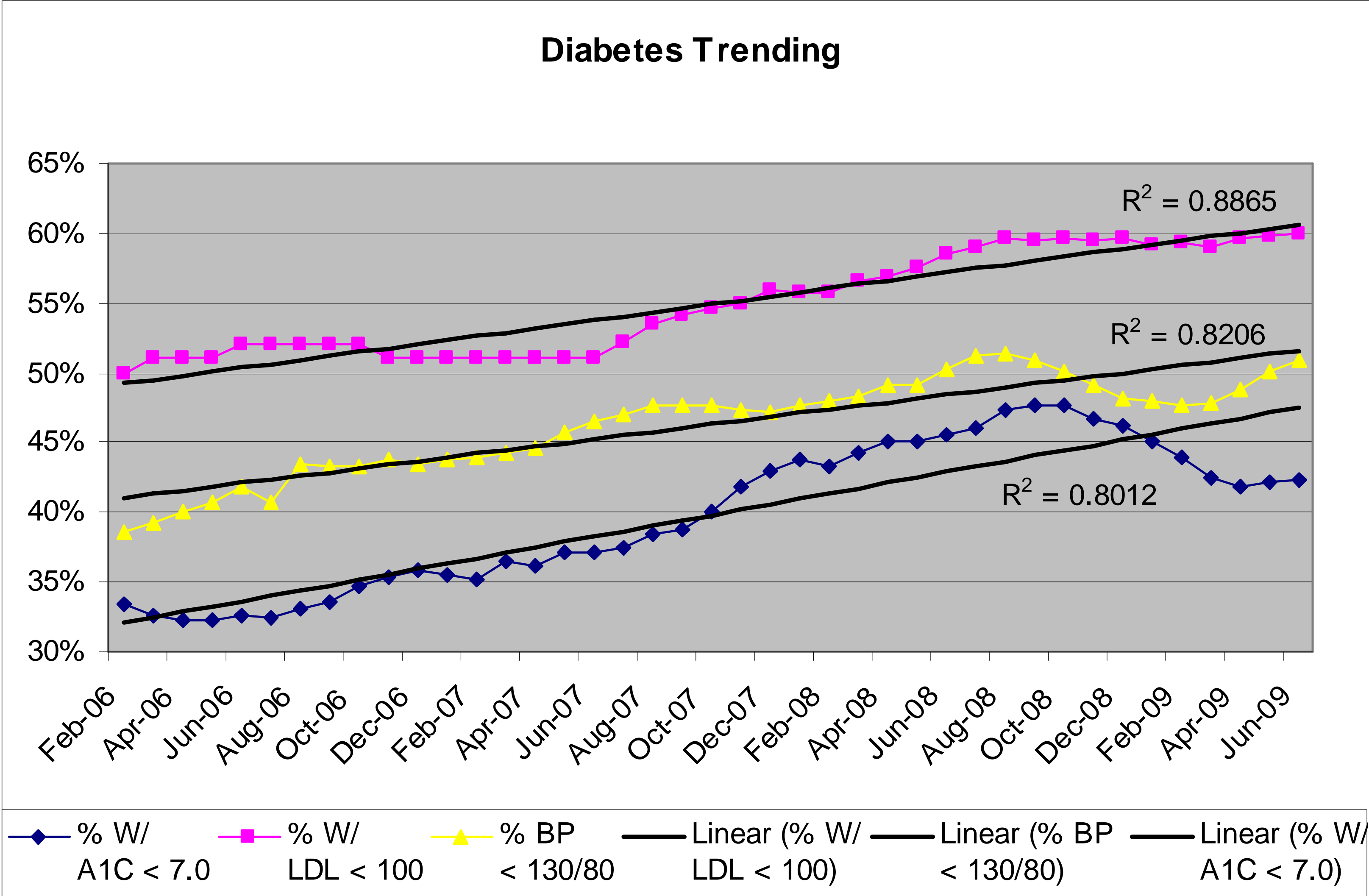
Impact: CHF Admissions



ProvenCare - Chronic®

Chronic Disease Optimization

Diabetes Intermediate Outcomes

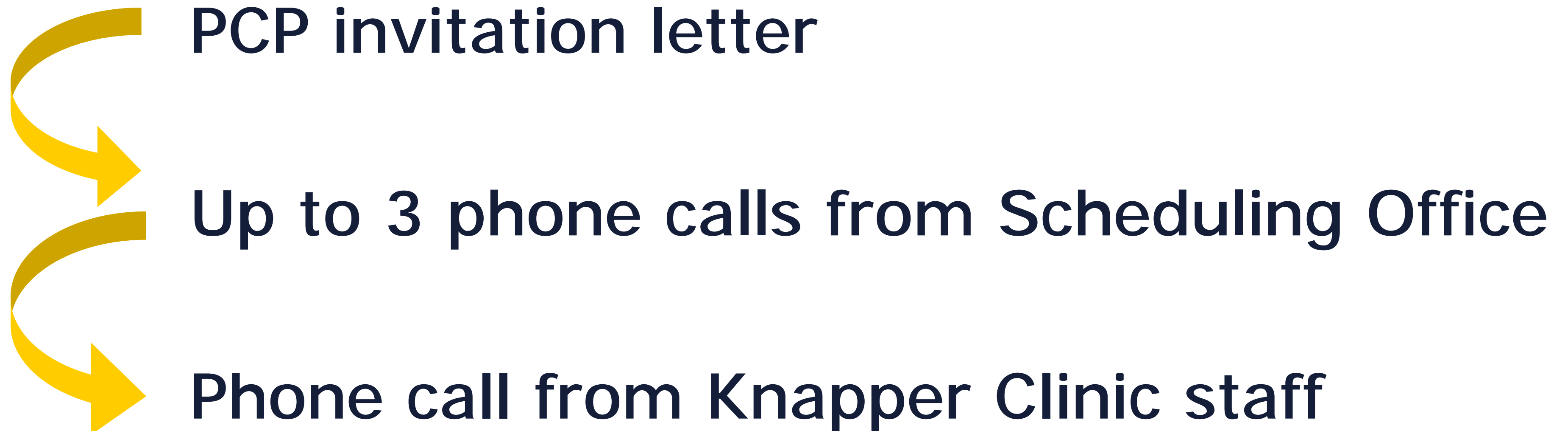


Diabetes: Resistant Control Group

- Despite the success of the Diabetes Bundle, **8% of the 21,667 known diabetic patients continue to have HgbA1C levels over 9%**
- Intervention target: Knapper Clinic
  - 1,074 diabetic patients
  - 10% had HgbA1C levels over 9%
  - This group of patients at highest risk for diabetic complication was targeted for our program

High Risk Diabetes Outreach Program Invitation Process

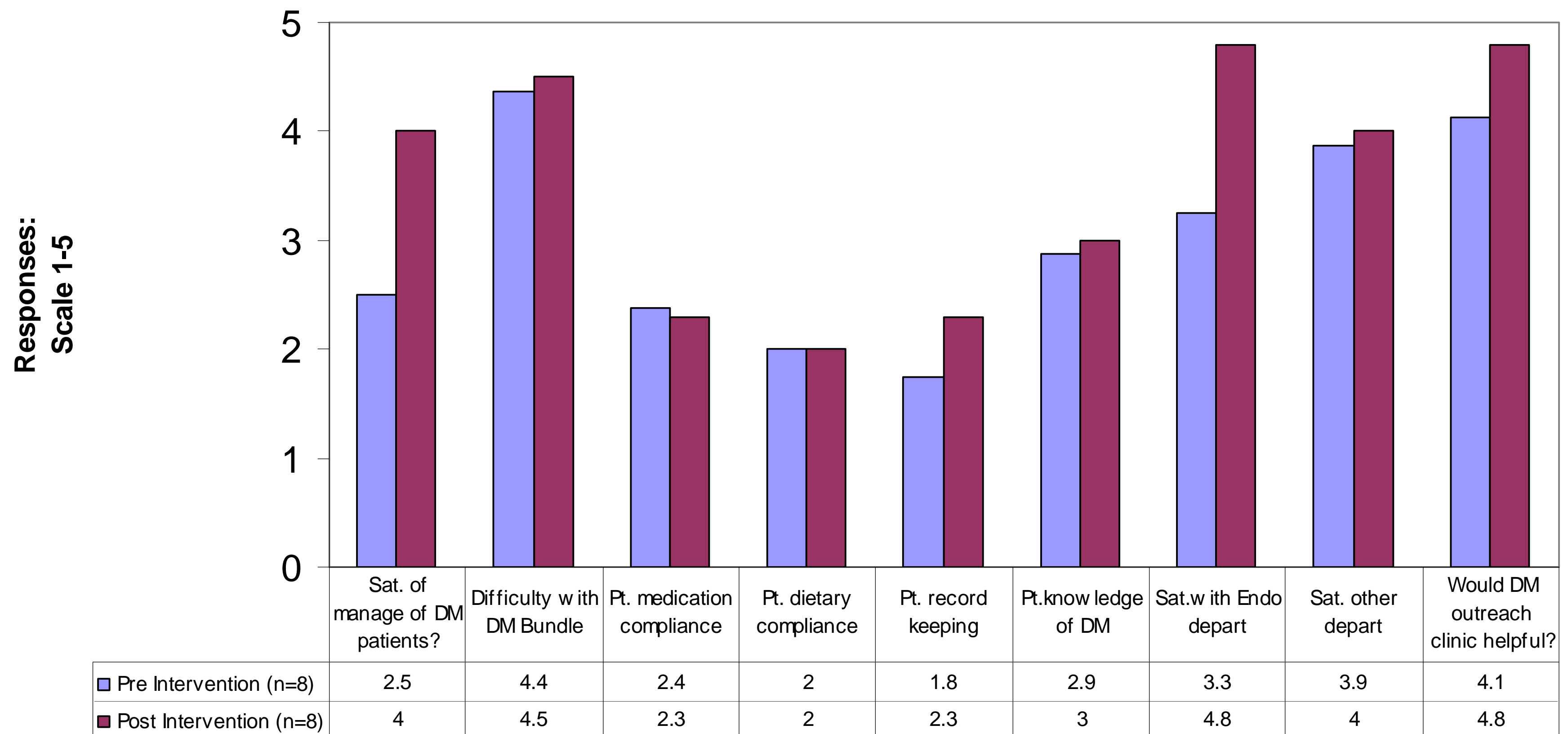
Invitation Process:



Results: Change in HgbA1C% (Cases vs. Baseline)

Time to F/u HgbA1C%	Change in HgbA1C%	P-value
8 weeks (n=39)	-1.57	<0.001
15 weeks (n=23)	-1.83	<0.001

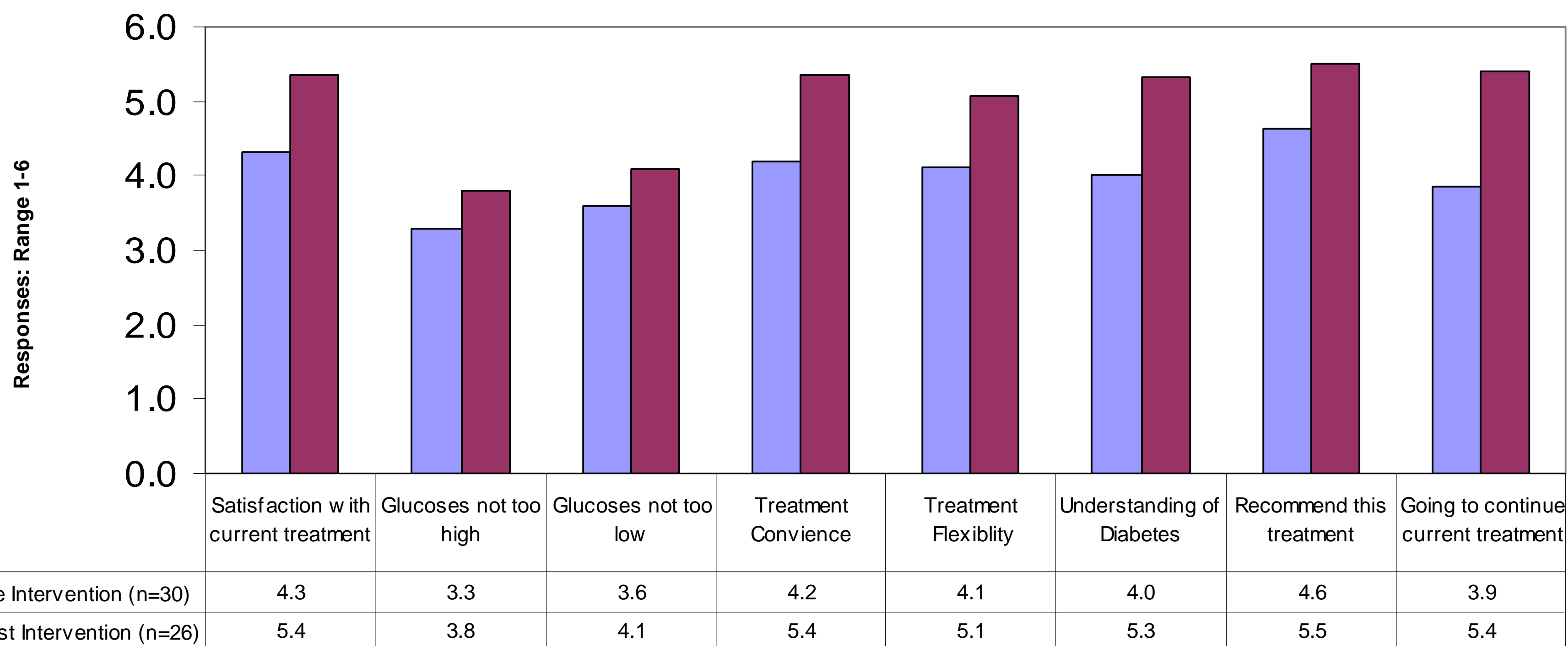
High Risk Diabetes Outreach Program Provider Survey



	Sat. of manage of DM patients?	Difficulty with DM Bundle	Pt. medication compliance	Pt. dietary compliance	Pt. record keeping	Pt.knowledge of DM	Sat.with Endo depart	Sat. other depart	Would DM outreach clinic helpful?
Pre Intervention (n=8)	2.5	4.4	2.4	2	1.8	2.9	3.3	3.9	4.1
Post Intervention (n=8)	4	4.5	2.3	2	2.3	3	4.8	4	4.8

High Risk Diabetes Outreach Program: Patient Survey

Patient Surveys: Pre & Post

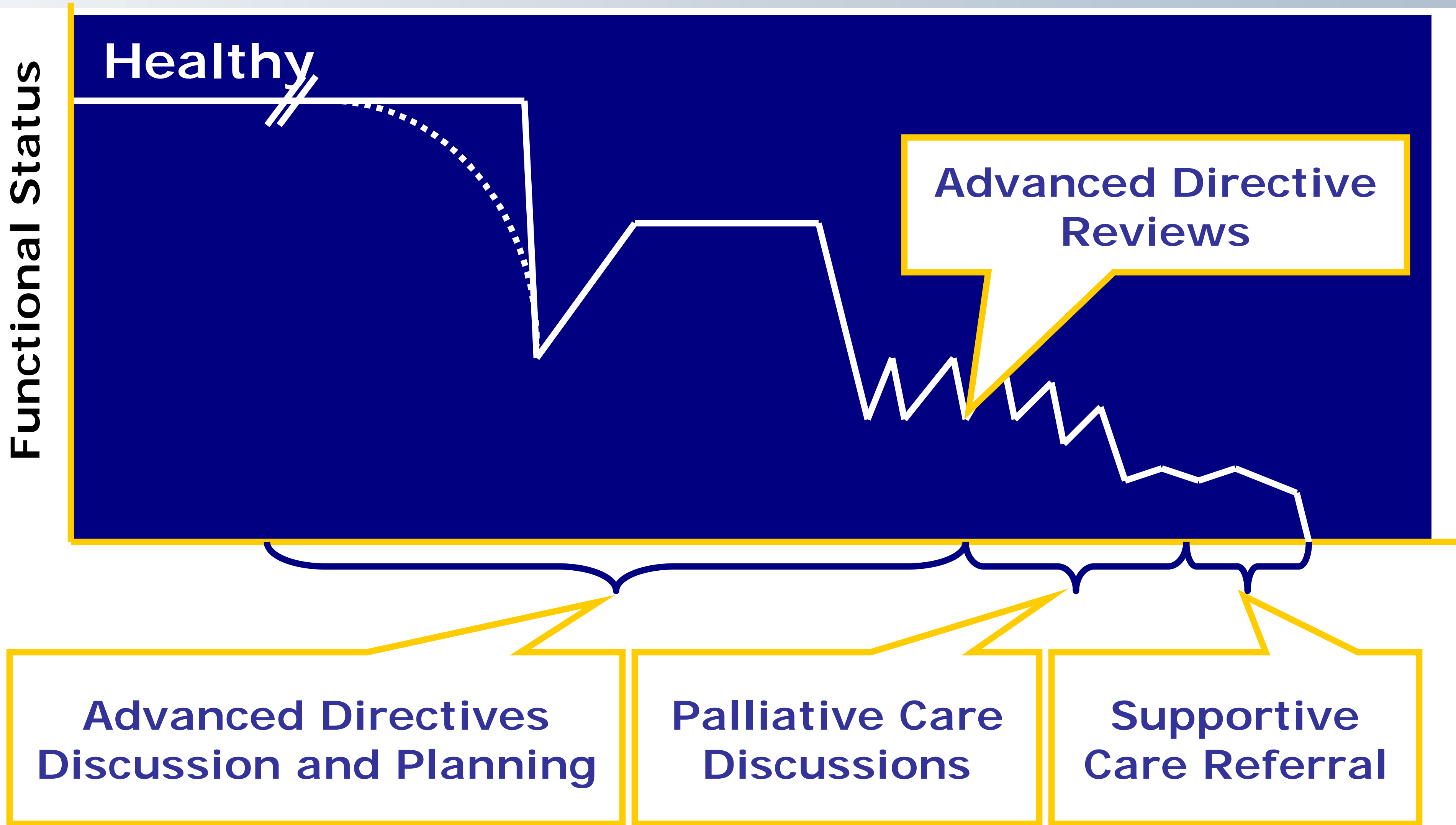


	Satisfaction w ith current treatment	Glucoses not too high	Glucoses not too low	Treatment Convience	Treatment Flexiblity	Understanding of Diabetes	Recommend this treatment	Going to continue current treatment
Pre Intervention (n=30)	4.3	3.3	3.6	4.2	4.1	4.0	4.6	3.9
Post Intervention (n=26)	5.4	3.8	4.1	5.4	5.1	5.3	5.5	5.4

Qustions from Diabetes Treatment Satisfaction Questionnaire (DTSQ) © 1993 Dr. Clare Bradley, Diabetes Research Group, Englan

End of Life Planning and Care

Chronic Disease Spectrum and End of Life Activities



Thank You.