Sentara Medical Group
Advanced Medical Home Strategies

Sustaining success in primary care redesign

Presenters :

M. Colette Carver, F.N.P., Director of Transformation of Care

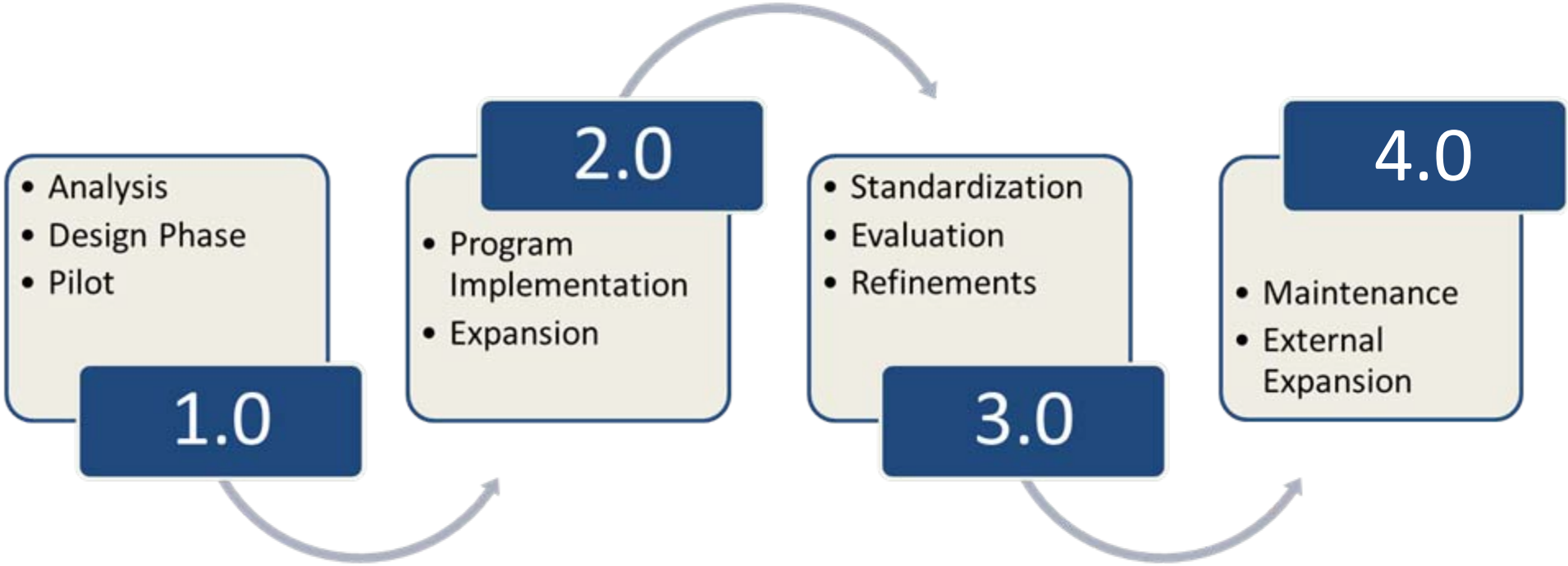
Melvina Tyson, R.N., Project Manager Transformation of Care

Sentara Medical Group

SENTARA®

Sentara Medical Group

A Deliberate Design



SENTARA®

Guiding Principles

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

Goals

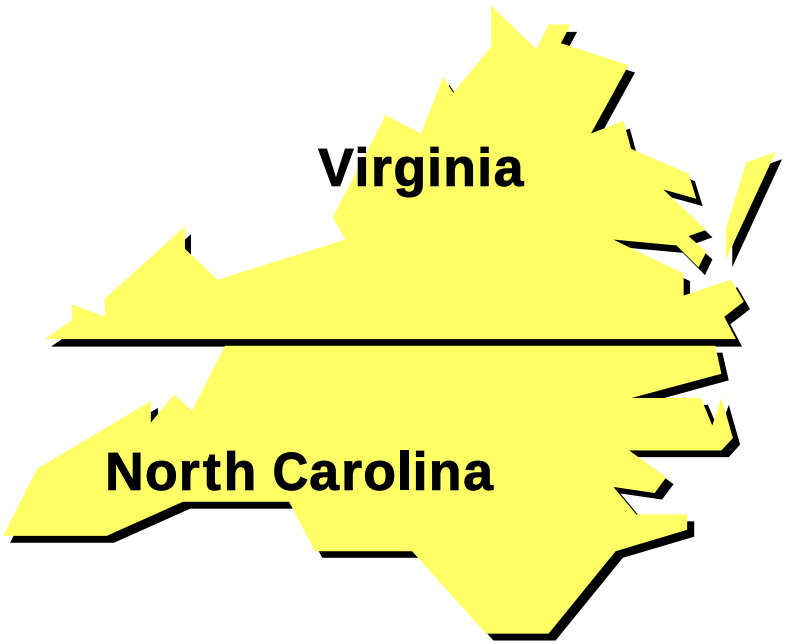
- Improved Clinical Outcomes
- Increased Patient Access
- Performance Improvement of Operations – Bend the Cost Curve
- Provider/Staff/Patient Satisfaction

SENTARA®

Essential components of Office redesign

NCQA Recognitions

- PCMH-38 All Level 3
- Diabetes 96
- Heart Stroke 78



~237,000 served by PCMH providers 12.4% of Hampton Roads Population

SENTARA®

Strategy - 1.0

I. Transformation of Care Team (TOC)

- Clinical and Admin team defined
- External Best Practices
- Established industry goals were chosen for alignment - HEDIS, NQF, PQRS, MU
- Role definitions
- Staffing models

II. Care Management

- RN Care Managers
- High opportunity patient focus and cohort followed
- Transitions of care contact for defined patients

III. Data

- NCQA Patient Centered Medical Home
- NCQA Diabetes and Heart Stroke
- Practice Scorecard

IV. Cultural of Excellence

- Early adopters in Primary Care lead redesign
- Alignment with System's Leadership Development Program

SENTARA®

Compendium of Best Practices

	Geisinger		Group Health		Allina		QLIMG		Health Partners	
Goals	Results	Interventions	Results	Interventions	Results	Interventions	Results	Interventions	Results	Interventions
Reduce hospitalization admissions	20% ↓	**Case managers** on site to track high risk patients, systematic followup of all hospital/SNF discharges, telephonic outreach, open access scheduling , medication reconciliation	→	**Case managers** track high risk patients, systematic followup of all hospital/SNF discharges	*Not available*	**Case managers** track high risk patients, systematic followup of all hospital/SNF discharges, Open access, same day appointments, 24/7 scheduling	*Not available*	**Case managers** track high risk patients, systematic followup of all hospital/SNF discharges, Same day appointments	24% ↓	Improved patient access, online scheduling; **case management** for high risk patients, coordination of care
Reduce re-admissions	40% ↓		→		*Not available*		*Not available*		↓	
Emergency room total cost	7% ↓	Embed case managers on site to track high risk patients, systematic follow-up of all ED discharges, telephonic outreach, **open access scheduling** , medication reconciliation	29% ↓	Case managers track high risk patients, **F/U calls 3 days after ED visits**	*Not available*	Case managers track high risk patients, systematic followup of all ED discharges, **Open access, same day appointments**, 24/7 scheduling	*Not available*	Case managers track high risk patients, systematic follow-up of all ED discharges, **Same day appointments**	39% ↓	**Improved patient access, online scheduling** case management for high risk patients, coordination of care
Quality Scores for DM/CAD	↑	**Disease registries**, preventitive care, proactive tracking of low risk patients, monthly meetings to review quality data.	1.4% ↑	**Disease registries**, MD performance reports, daily team huddles, pre visit outreach/chart review, planned preventive visits, telephonic/email visits, abnormal test outreach	↑	**Disease registries**, MD performance reports, daily team huddles, previsit outreach/chart review, standing orders for nursing staff, after visit summary for patient education	↑	**Disease registries**, MD performance reports, daily team huddles, pre visit outreach/chart review, planned preventative visits, focus on "frequent fliers"	129% ↑	**Disease registries**, proactive outreach and management, telephonic coaching, after visit summary, health maintenance
Improve patient satisfaction	↑	Call routing to care team, Proactive outreach, e-visits, phone visits, Patient and family engagement and education	↑	Call routing to care team, Proactive outreach, communication of team roles to patients, e-visits, phone visits	9% ↑	Same day appointments, MyChart, Call routing to care team, Proactive outreach, 24/7 scheduling, after visit summary, advanced care planning	↑	Same day appointments, Call routing to care team, Proactive outreach, communication of team roles to patients, phone visits	↑	Reducing wait times, surveys, patient portals
Improve physician satisfaction	↑	Establish care teams, **define roles and protocols** for all staff	↑	Establish care teams, **define roles and protocols** for all staff, rooming standards, daily huddles, pre-visit planning	18% ↑	Establish care teams, **define roles and protocols** for all staff, rooming standards, daily huddles, on site testing	↑	Establish care teams, **define roles and protocols** for all staff, rooming standards, daily huddles, pre-visit planning, on-site testing	↑	Establish care teams, **define roles and protocols** for all staff, pre-visit planning
NCQA recognition	↑	All of the above	↑	All of the above			↑	All of the above	↑	All of the above

Strategy - 2.0

I. Transformation of Care Team

- TOC and Sentara Clinics Optimization of the Patient Experience
- Best Practices Implemented with further development

II. Care Management

- RN Care Manager expansion to all patient transitions
- Sentara Quality Clinical Network
- Pharmacists

III. Data

- Patient Centered Medical Home Meetings
- Scorecard and compensation goals aligned
- Enhanced Access

IV. Cultural of Excellence

- Included 19 more practices
- Expanded Early Adopter groups in all regions
- Physician mentorship of Physician Practice Leader

SENTARA®

Transformation of Care, Primary Care Redesign- Pioneer Guide

Mission	Secretary /Front Desk	MA/LPN	RN/Care Manager	Provider	Manager
Same Day Appointment	Schedule appointments made within 24 hours using SDA visit type			Support and provide same day appointments in the template	Monitor SDA appointments
	When delegated contact patients within 1 business day verify if F/U appt is made by the surge secretary prior to calling the patient: • Yes - call and confirm appt • No - call schedule f/u appt Document attempt at call or actual contact using lephone encounter "hospital follow up" as reason for encounter.	Contact patients within 1 business day as directed by Provider, may delegate to secretary. Verify if F/U appt is made by the surge secretary prior to calling the patient: • Yes - call and confirm appt • No - call schedule f/u appt Document attempt at call or actual contact using Telephone encounter "hospital follow up" as reason for encounter.	Perform an assessment call for VIP population and those with specified diagnoses (e.g. AMI/CHF/COPD/Diabetes/ Pneumonia/Sepsis)	Attach ADT folder to all staff members for shared work. Identify patients for staff contact	• Forward daily Clarity report displaying 7 day follow up visits to Clinical Teams. Assign shared administrator
	bute medication list to the patient for review and edits to be completed prior to rooming	Reconcile medications, enter and pend needed chronic meds, verify pharmacy	Reconcile medications for the VIP population	Verify/Approve/Deny medications	Monitor Meaningful Use Report
		Utilize rooming-in tool: Prepare patient for chronic visit (e.g. remove footwear of DM, .NCQA smart phrase in patient instruction). Review and update health maintenance measures.		Sign pending Health Maintenance entries	
	Print schedule for huddle Participate in huddle: dentify staff or workflow issues. Identify patient care needs document under appointment notes.	Participate in huddle: Identify staff or workflow issues. Identify patient care needs document under appointment notes. Identify VIP patients on schedule	Participate in huddle: Identify VIP patients Bi-weekly Huddle with provider to discuss VIP population	Participate in daily huddle: Identify staff or workflow issues. Identify patient care needs document under appointment notes. Identify VIP patients on schedule	Monitor all appropriate staff are participating pre-visit planning activity. Record on daily rounding log.
	ont desk: Collect all pertinent paperwork 1 day prior to visit: print medication list				
	tify/contact/schedule appointment patient(s)not seen in 180 days	Reviews for clinical indicators that are overdue. Enter and pend orders for provider		Review quality measures and discuss in medical home meetings	Monitor indicators update chart of deceased patient and update PCP
Advance Care Planning (VIP)	Distribute Advance Directive form	Ask the VIP patient if they have an Advance Directive and document in EPIC	Advance Care Planning facilitated discussion for VIP population	Introduce Advance Care planning to VIP and/or conduct facilitated discussion or "hand-off" to MHCM	N/A
Quality Measures	Receive and adjust workflows to improve quality	Receive and adjust workflows to improve quality	Review quality data Receive and adjust workflows to improve quality	Review quality data, identify areas of opportunity with action steps to improve	Monitor quality data and communicate focus areas
VIP Population	Identifies VIP patient by viewing flag in cadence	Identifies VIP patient by viewing flag in cadence	Manage VIP list, update at medical home meetings	Review list, discuss with MHCM bi-weekly	Supports the provider and Care coordinator in huddle
	/explain the AVS to the patient at the end of the courage active MyChart user to review AVS online	Print and explain the AVS at the end of the visit	Print/explain the AVS to the patient at the end of the visit for VIP population	Include patient instructions in the AVS	Monitor Meaningful Use Report
Customer Service	Greet the patient with a smile and a friendly salutation, ask the patient if you have addressed all of their needs prior to seeing the provider	Greet the patient with a smile and introduce yourself and title, address the patient by using the patient's last name, maintain a professional attitude	Greet the patient with a smile and introduce yourself and title, maintain a professional attitude	Greet the patient with a friendly salutation, Review NRC Picker, develop action plan quarterly	Print/Review NRC Red/Green Light report and comments, Develop action plan quarterly
MyChart Enrollment	Ask patient to sign up for MyChart at registration, print AVS with pre-populated MyChart activation code	Ask the patient to sign up for MyChart	Ask the VIP population to sign up for MyChart	Encourage the patient to sign up for MyChart and explain the benefits	Review MyChart stats

SENTARA®

Strategy - 3.0

I. Transformation of Care Team

- Maintain Best Practices through standardization
- Integration across specialties - building Medical Neighborhoods

II. Care Management

- RN Care Managers & Pharm Ds refined focus on high opportunity population
- Transitions of care across all venues
- Coordination with Optima Health Plan's Case Management

III. Data

- Expanded Scorecard measures
- Shared quality metrics established for all SQCN providers

IV. Cultural of Excellence

- Regional Medical Directors
- Practice Physician Lead – Administrator Dyad

SENTARA®

Strategy - 4.0

I. Transformation of Care Team

- Expanded Clinical Focus to Improve Outcomes
- IT Innovations for Access and Service
- Coding and Documentation Model for high opportunity population

II. Care Management

- RN Care Managers coordinate transitions for non network facilities
- Population Management integration with multiple payers

III. Data

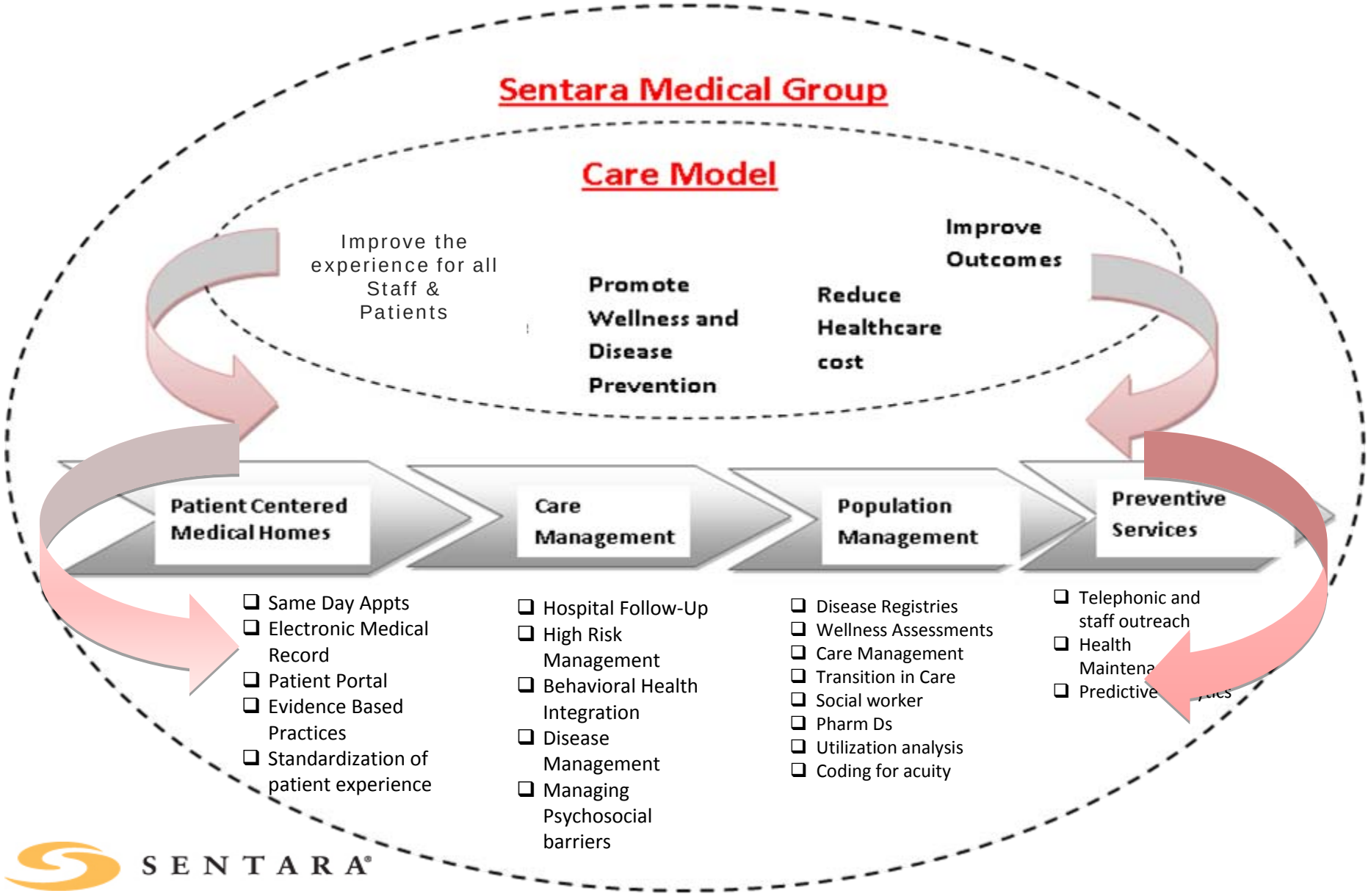
- Expanded Scorecard paired with population management goals
- STAR Measure Reporting
- Coding accuracy that reflects the acuity of patient population

IV. Cultural of Excellence

- Volume to Value experience with new Medicare Advantage population
- Increased responsibility for Physician leaders

SENTARA®

Sentara Medical Group
Transformation of Care "Care Model"



SENTARA®

Questions?