STEPSforward™
POWERED BY THE AMERICAN MEDICAL ASSOCIATION

"Improving Professional Satisfaction and Practice Sustainability Through Office Transformation"

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ACP New Mexico Chapter
Albuquerque, NM
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AMA

Today's conversation

- Discuss the current changes in the practice environment and payment reform as a **context** for practice transformation
- Explore some of the causes for physician **burnout** and its consequences
- Introduce the AMA **STEPSForward** program to aid in office redesign

Why Do I Need to Change?

The organization and financing of healthcare is rapidly changing. Creating an agile organization around you may be the best way to succeed!

Key assumptions

- Now, more than ever…high quality, effective patient care is a **team sport**
- **"Patient-centeredness"** is more than a catch-phrase…it must be *real, palpable and everyone's responsibility*
- **Integration** and **collaboration** must trump fragmentation and autonomy
- Care must be **systematic** and **IT enabled** for better reliability and better outcomes for patients
- The **visit** is no longer the "central commodity of healthcare"

= Influences our thinking on an issue

Healthcare delivery system trends

- Physician leaders
- Information technology enabled
- Clinical integration
- Prepaid global payment system

-Robert Pearl, MD –CEO, PMG

"80% of the strategies for managing population health and controlling total healthcare costs are related to primary care activities."

Hero model or real team care?

Hero model

- Physician in charge- “Captain of the ship”
- Physician authorization required for most orders
- Staff works to optimize physician workflow and **throughput**

Team care

- Physician provides clinical expertise and knowledge
- All make decisions appropriate for level of work
- Entire team participates in optimizing **outcomes for patients**

Team approach to care

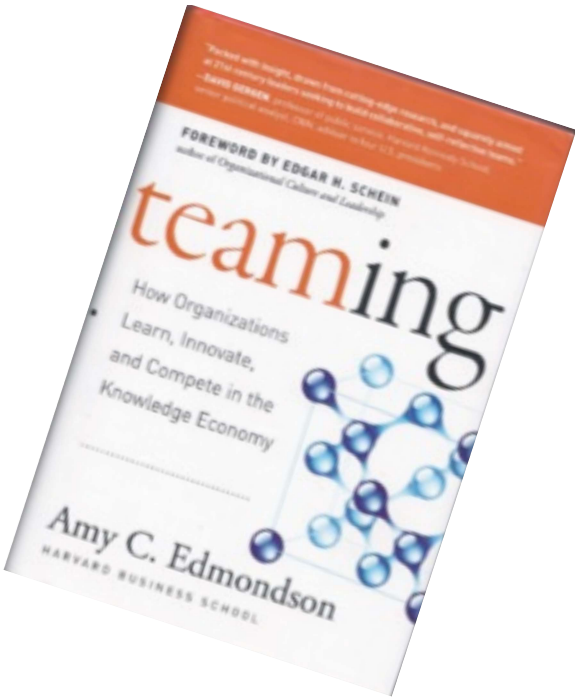
- Much more than a list of participants
- A **strategic distribution** of the work should be the goal
- Both **“small team”** and **“big team”** are important for success
- Workflows and IT systems must support team **interaction and communication**

Characteristics of a team

- A group of **skilled** individuals
- Driven by a common **goal**
- Agree on a game **plan**
- Play or **work together** often enough to get to know each others strengths and weaknesses
- Regularly **discuss** the play and **interactions** to improve on achievement of the goal
- Ideally has an experienced coach or captain to observe the play and make suggestions for **improved performance** on pursuit of the goal

Strategic distribution of work

- Categorize the work
  - -- *Complex work*
  - -- *Standard work*
  - -- *Innovative work*



- Identify the standard work, characterized by "rules-based decision making" and move it into standing orders and protocols
- IT systems can help to organize the work and allow all team members to contribute at the appropriate level

"**Teaming-** How Organizations Learn, Innovate and Compete in the Knowledge Economy," Amy Edmondson, Jossey-Bass 2012

Patient/family/caregiver engagement

- The "**block-buster drug**" of the 21st Century
- **Access** redefined-"How can we help you?"
- Patient **self-management support**
  - *Motivational interviewing*
  - *Informed medical decision making*
  - *Shared goal setting*
  - *Outreach and between visit follow up*
- **Patient** reported **outcomes** of care (beyond **CAHPS**)

www.patientfamilyengagement.org

Technology and connectedness

- We must apply the great technology we already enjoy in our everyday lives to **enhance the healing relationship**
- Knowledge management, communication, education and information exchange
  - Community-wide Health Information Exchange (HIE)
  - Electronic health records
  - Patient portals
  - Email with patients and e-visits
  - Video visits

Patient portals enhance relationships

- Full digital engagement on a **mobile platform**
- Email with patients
  - *Triage and distribute like phone messages now*
  - *Reduces phone traffic*
  - *Less keyboarding by staff*
- SMS for coaching and reminders
- Appointment and Rx requests
- Education and support groups
- Video visits for elderly

Population health puzzle pieces

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Risk-Stratified Care Management

PRACTICE MANAGEMENT

Practice Transformation

- The Patient-Centered Medical Home
- Benefits of the PCMH
- Basic PCMH Concepts
- Intermediate PCMH Concepts
- Advanced PCMH Concepts
- Risk-Stratified Care Management
- PCMH Incentive,

High-Impact Change: Risk-Stratified Care Management

Risk-stratified care management (RSCM) is the process (1 page PDF) of assigning a health risk status to a patient, and using the patient's risk status to direct and improve care. The goal of RSCM is to help patients achieve the best health and quality of life possible by preventing chronic disease, stabilizing current chronic conditions, and preventing acceleration to higher-risk categories and higher associated costs.

Identifying a patient's health risk category is the first step toward planning, developing, and implementing a personalized care plan by the care team, in collaboration with the patient. For some, the plan may address a need for

SEE ALSO

- AAFP RSCM Rubric (1 page PDF)
- Identifying High-risk, High-cost Patients Is Step One to Improving Practice Efficiency from *AAFP News*

RELATED RESEARCH

- Risk-stratification methods for identifying patients for care coordination. (www.ajmc.com) Am J Manag Care. 2013;19 (9):725-732.

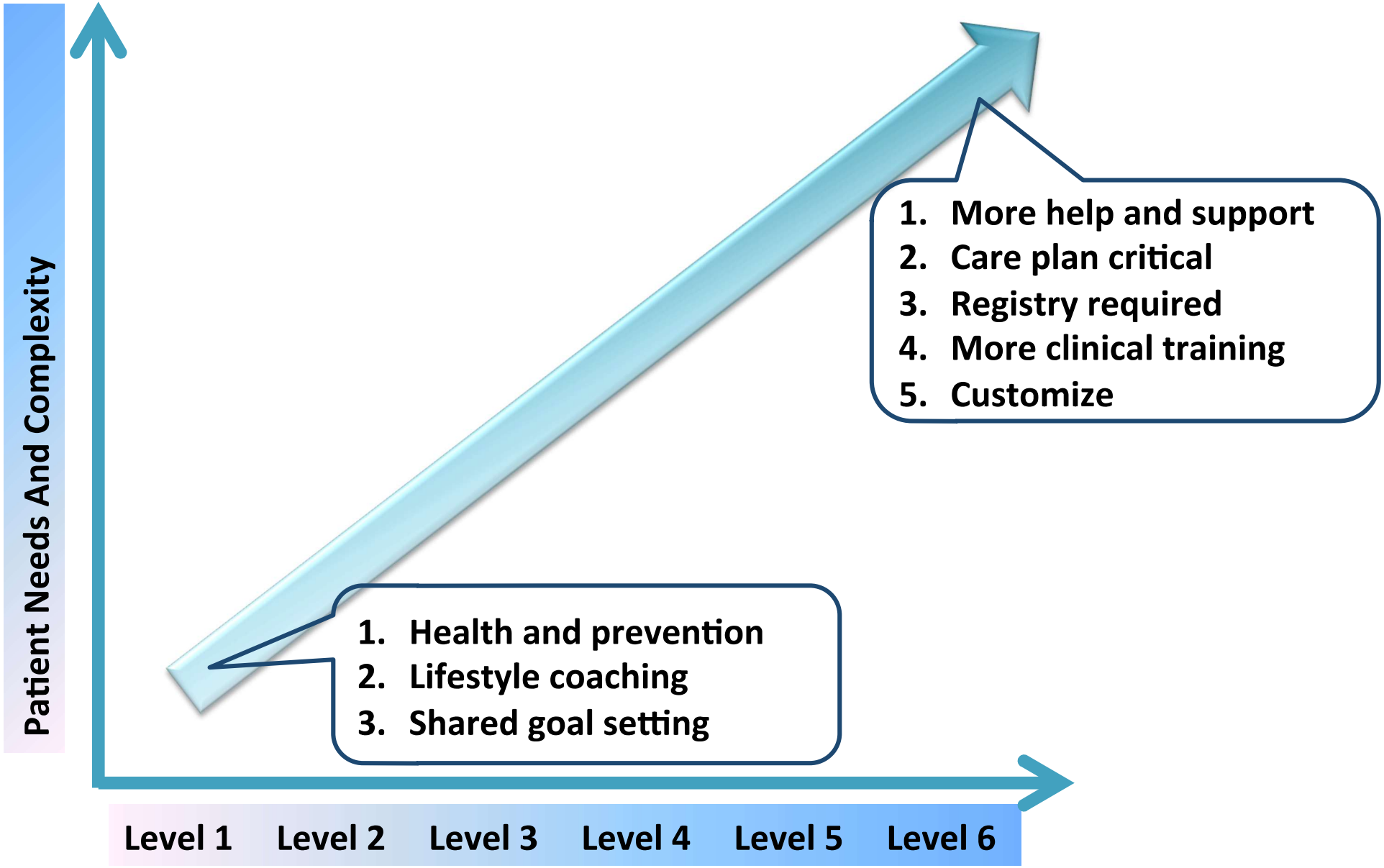
Risk-Stratified Care Management and Coordination

AMERICAN ACADEMY OF FAMILY PHYSICIANS

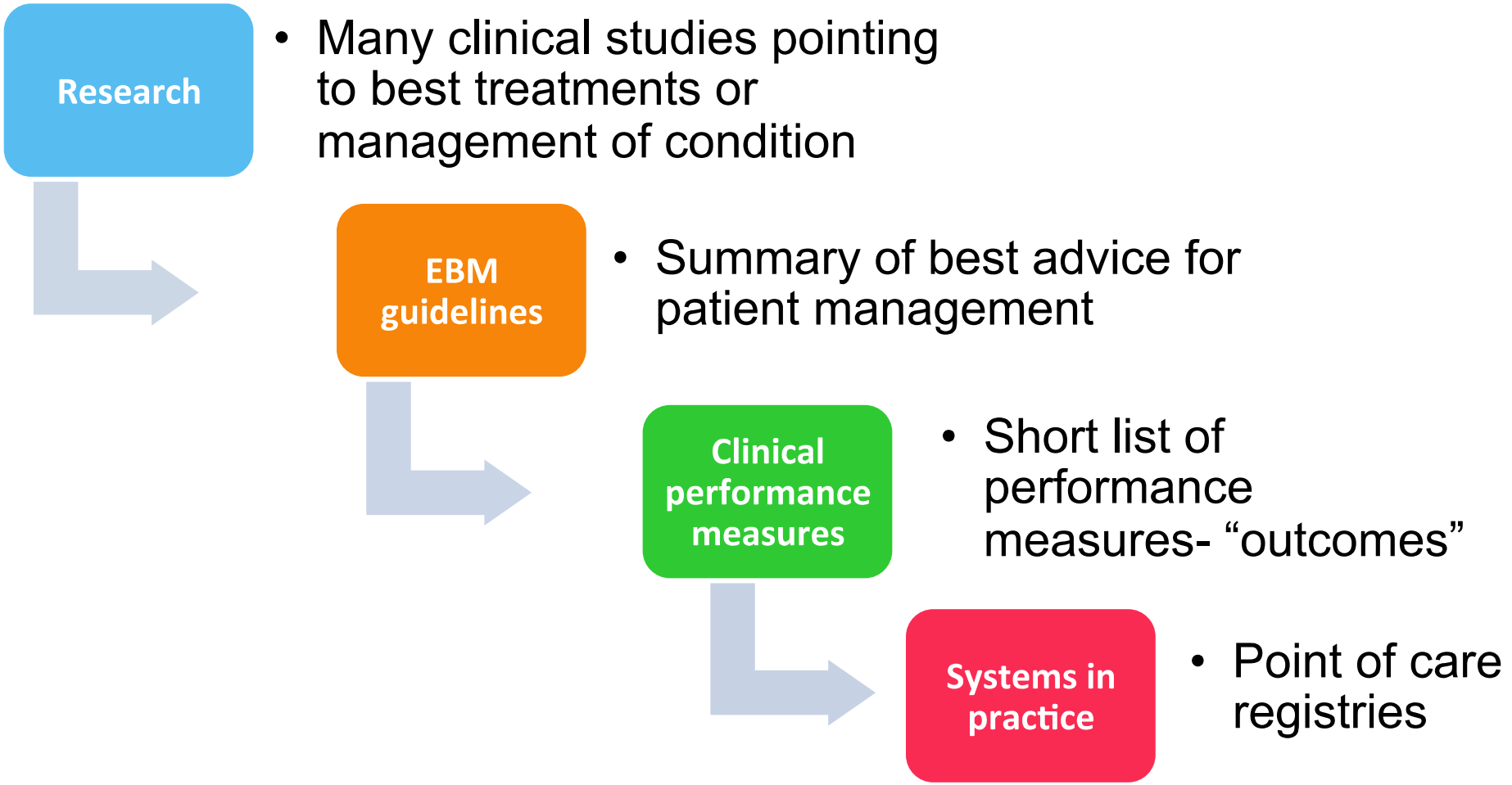
Table 1: Examples of Potentially Significant Risk Factors

Clinical Diagnoses, Behavioral Health, Special Needs	Potential Physical Limitations	Social Determinants	Utilization/Claims Data	Clinician Input (Personal Knowledge)
– Any chronic disease, particularly one that is not in control or at desired goal – Chronic pain – Substance abuse (alcohol/drug/tobacco) – Terminal illness – Advanced age with frailty – Multiple co-morbidities – Pre-term delivery of newborn – Child, youth, or adult with special needs – Anxiety, schizophrenia, bipolar, depression, or other behavior affecting health – Dental health – Dementia/Alzheimer's disease	– Non-ambulatory – Needs Assistance with Activities of Daily Living (ADLs) – Severely diminished functional status – Declining eyesight – Extreme weakness or fatigue – At risk for falls	– Lack of financial or family support that impacts care – Unemployed – No health insurance – Low health literacy – Unsafe home environment – Homeless – Lives alone and needs assistance with ADLs – Transportation for health care appointments is difficult – Language barriers	– Frequent hospitalizations (particularly heart failure, GI disorders, and pneumonia) – Frequent office, ER, or urgent care visits – Multiple providers – Hospital readmission within 30 days – Major procedure in last year – Chronic kidney disease – Brain trauma – Expensive medications	– Polypharmacy – Patient is taking several medications that may not all be needed and/or could have potential for interactions – High-risk medications – Non-compliant with treatment plan – Confusion with medications or following the treatment plan – Recent move to long-term facility or other transition of care – Spouse (who was the caregiver) recently deceased – Lack of engagement in care plan – Low confidence or ability for self-management – Answer to the question: Is this patient at higher risk for dying within the next year?

Risk-stratified care management



EBM process to better patient care



5 Critical functions of a POC registry

1. **List** of all patients with the condition
2. Patient status screen or **"snap shot"** of the EHR to identify gaps in care
3. **Aggregate** of all patients on list with results and targets
4. Support for **outreach** efforts
5. Quality reporting as **byproduct of the process of care**

Disease Management Cycle

Asthma: Planned Annual Care

Acute Visit → (3-5 Days) Follow Up Wheezing Visit (Diagnostic Visit for Asthma)

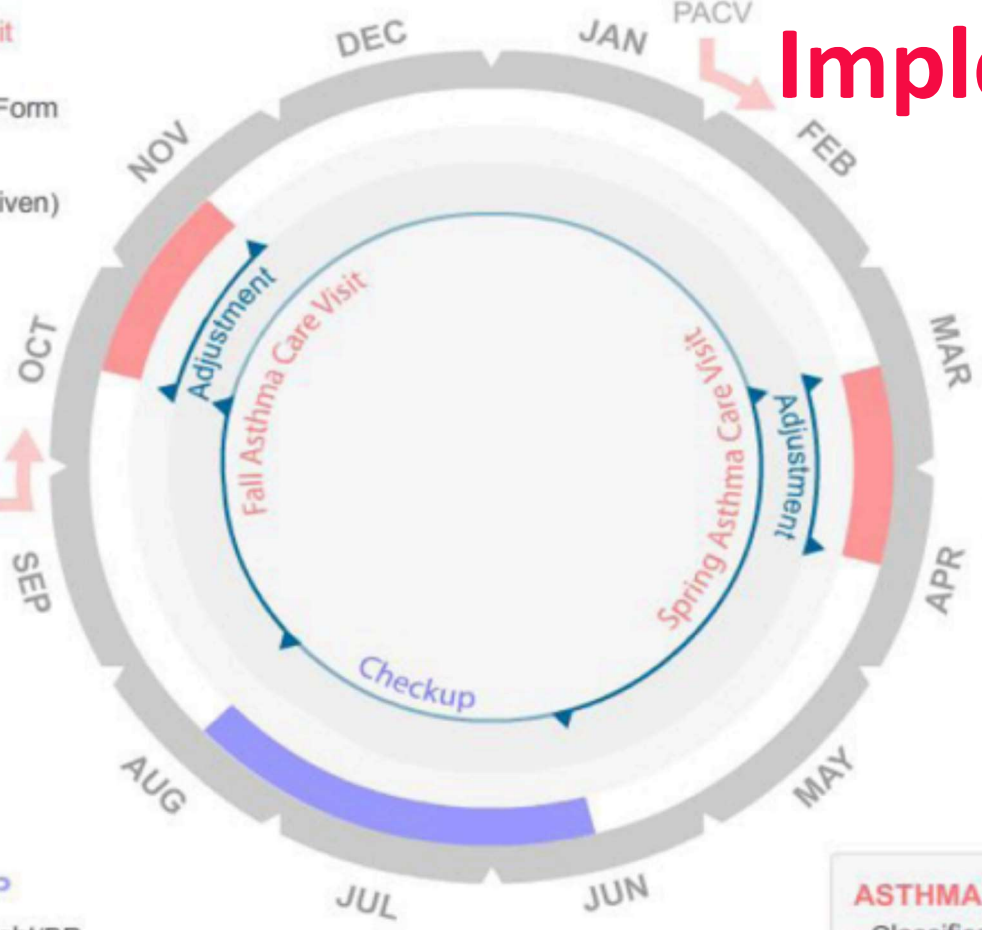
1 Month

PACV

Implementation

FALL
Planned ASTHMA Care Visit

"Winter Wheezer"
- Asthma Control Test (ACT) Form
- Spirometry (as indicated)
- Asthma Action Plan
- Flu Vaccine (if not already given)



Acute Visit → (3-5 Days) Follow Up Wheezing Visit (Diagnostic Visit for Asthma) → (1 Month) PACV

SPRING
Planned ASTHMA Care Visit

"Springtime Sneezer-Wheezer"
- Asthma Control Test (ACT) Form
- Spirometry (as indicated)
- Asthma Action Plan

CHECKUP

- Height/Weight/BP
- ASTHMA: Spirometry (if indicated)
- Review Asthma Action Plan

ASTHMA Attributes (Registry)

- Classification (Intermittent / Persistent)
- Anti-inflammatory Medication
- Seasonality (Winter Wheezer/ Springtime Sneezer-Wheezer)
- Asthma Action Plan
- Flu Vaccine
- Asthma Visit Date

ASTHMA
CHECKUP

Care transition tasks

- Clarify modifications in the **care plan**
- **Reconcile medications** with pre-hospital orders, supplies at home and effectiveness for patient
- Understand level of help and **support needed** from others and arrange for necessary services
- **Solid transfer** of responsibility and follow up care
- Re-integrate patient into the **community of care**
- **Socio-economic** and **behavioral health** issues must be addressed

Emergency department

- Volume **trending up** nation-wide
- Increasing role for **retail clinics** and urgent care
- **Primary care capacity** in the community shackled by fee for service payment system

- Tremendous need for **better coordination** between ED and the primary care community (e.g. Coastal Medical in Rhode Island)

Financing healthcare for the future

The Patient Protection and Affordable Care Act has been a catalyst for change in the insurance industry but has also triggered a very different conversation about payment reform and delivery models

The changing payment environment

- How providers are **paid** makes a difference
- **Blended payment** modeled in Comprehensive Primary Care initiative from CMS

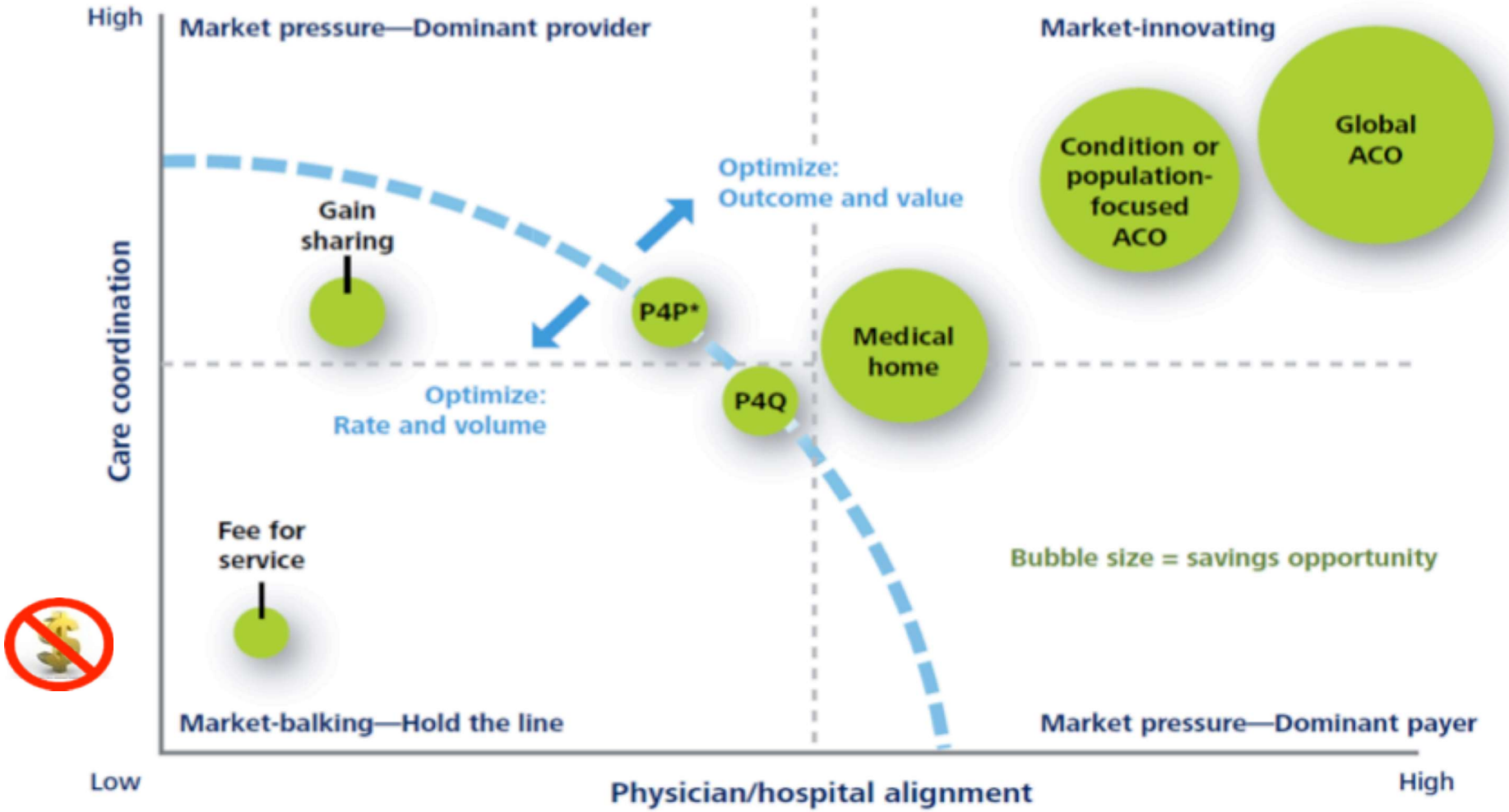
- CMS announces **value based** considerations will constitute 30% of payments by 2016 and 50% of payments by 2018
- ACOs must **distribute resources** internally in proportion to the value created for patients
- Primary care **infrastructure** needed for success

Medicare Advantage Plans and ACOs

- Both require robust ***primary care infrastructure*** and capability with embedded behavioral health

- ***Risk stratified*** care management and care coordination essential
- Clinical, financial and information technology ***integration is key to success***
- "Shared sense of responsibility for service, cost and quality" must drive the ***culture***

Figure 2. Transitions to value-based payment models will likely vary by market[17]



* Includes payment for episode of care.
Source: Deloitte analysis of models.

Graphic: Deloitte University Press | DUPress.com

"The Road to Value-Based Care-Your Mileage May Vary"
–Deloitte University Press 2015

ANNALS OF HEALTH CARE | MAY 11, 2015 ISSUE

OVERKILL

An avalanche of unnecessary medical care is harming patients physically and financially. What can we do about it?

BY ATUL GAWANDE

TABLE OF CONTENTS

It was lunchtime before my afternoon surgery clinic, which meant that I was at my desk, eating a ham-and-cheese sandwich and clicking through medical articles. Among those which caught my eye: a British case report on the first 3-D-printed hip implanted in a human being, a Canadian analysis of the rising volume of emergency-room visits by children who have ingested magnets, and a Colorado study finding that the percentage of fatal motor-vehicle accidents involving marijuana had doubled since its commercial distribution became legal. The one that got me thinking, however, was a study of more than a million Medicare patients. It suggested that a

How will we get from volume to value?

- Adjusting the dials on four **incentive types**
  - *Salary, Fee-for-service, Capitation and Pay for performance*
- Support for robust primary care **infrastructure**
- **Interim strategies** such as bundled payments or partial specialty capitation
- Global payments to organizations that are accountable for **triple aim results**
- Timeline for change

"If we build it…they will come" –*Field of dreams*

"If we build it with them… they will already be there"

Christine Bechtel

National Partnership for Women and Families

Three “take-away ideas”

1. The movement from **volume to value** is real and inexorable. It will **proceed slower** than desired by employers and governmental agencies and **faster** than desired by providers and health plans

2. Risk stratified care management and care coordination will soon be the **“standard of care”** without which providers and organizations will be considered lacking

3. Integration, collaboration and systematic team-based care are the **keys to success** in the future

Questions and Discussion

Physician Burnout

Exploring the causes and solutions for the current low level of professional satisfaction among physicians and staff

Physician burnout

- **Consequences**:
  - ↓ Patient satisfaction and quality
  - ↑ Medical errors and malpractice risk
  - ↑ Physician and staff turnover
  - ↑ Physician alcohol/drug abuse and addiction
  - ↑ Risk of physician suicide
- **Origin:**
  - ↓ Physical energy
  - ↓ Emotional energy
  - ↓ Spiritual energy

Like a bank account with the balance running low

Source: "Physician Burnout" Dike Drummond, MD- Family Practice Management, September/October 2015 www.aafp.org/fpm

Physician burnout

- **Symptoms**
  - Exhaustion
  - Depersonalization
  - Lack of efficacy
- **Five Main Causes**
  - The practice of clinical medicine
  - Your specific job
  - Having a life
  - The conditioning of your medical education
  - Leadership skills of your immediate supervisor

Source: "Physician Burnout" Dike Drummond, MD- Family Practice Management, September/October 2015 www.aafp.org/fpm

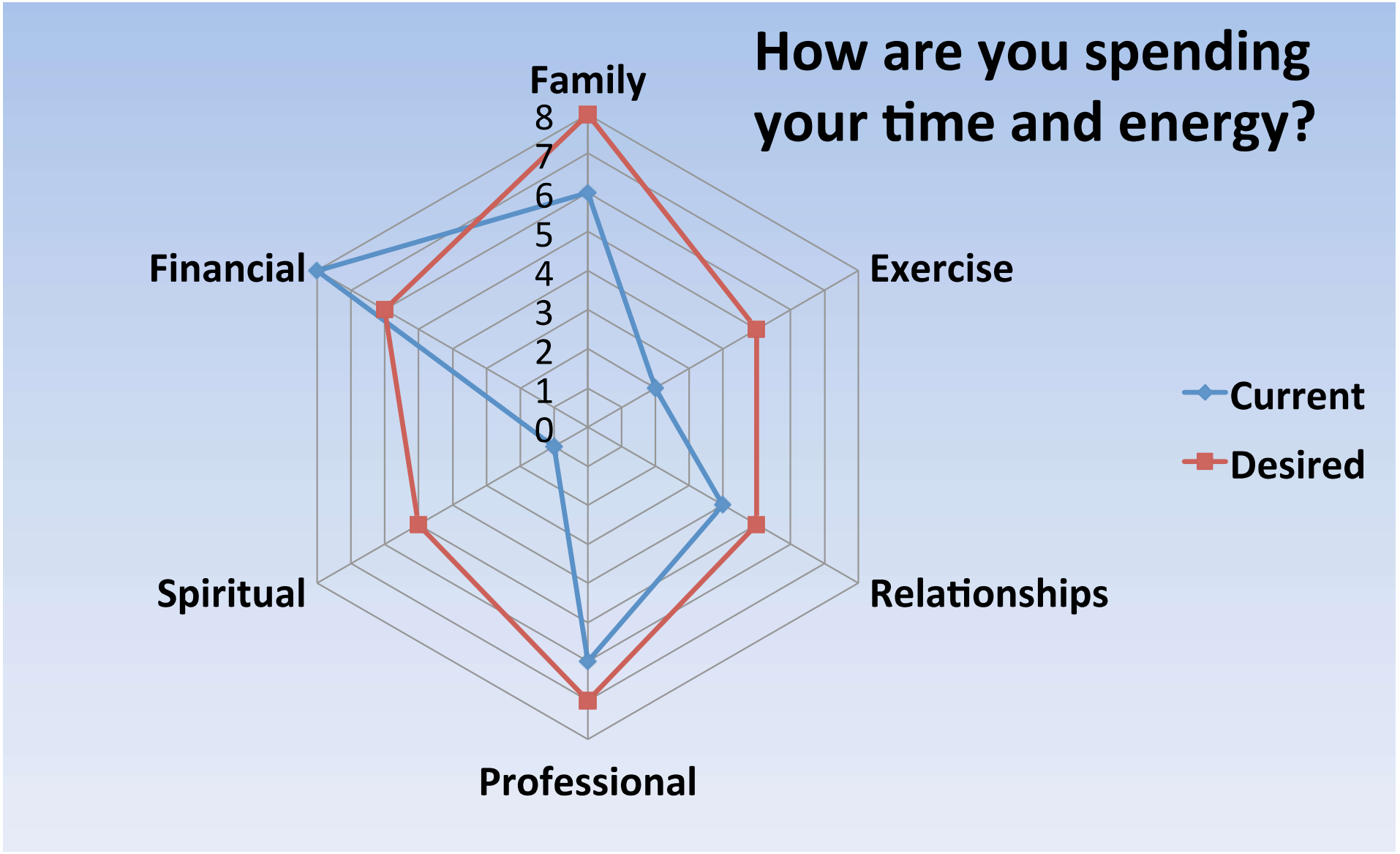
Contributing factors to stress

- The **world we live in** has changed dramatically in the last 10 to 15 years
  - Information overload
  - Connectedness…can't get away
  - Pace of life is up two notches
  - Change is everywhere in everything we do
- The **practice of medicine**
  - More consolidation => less autonomy
  - More measurement and accountability
  - Higher patient expectations for service
- Changes in **healthcare financing**
  - Volume to value
  - Cost pressures
  - Proactive payment strategies from both employers and government

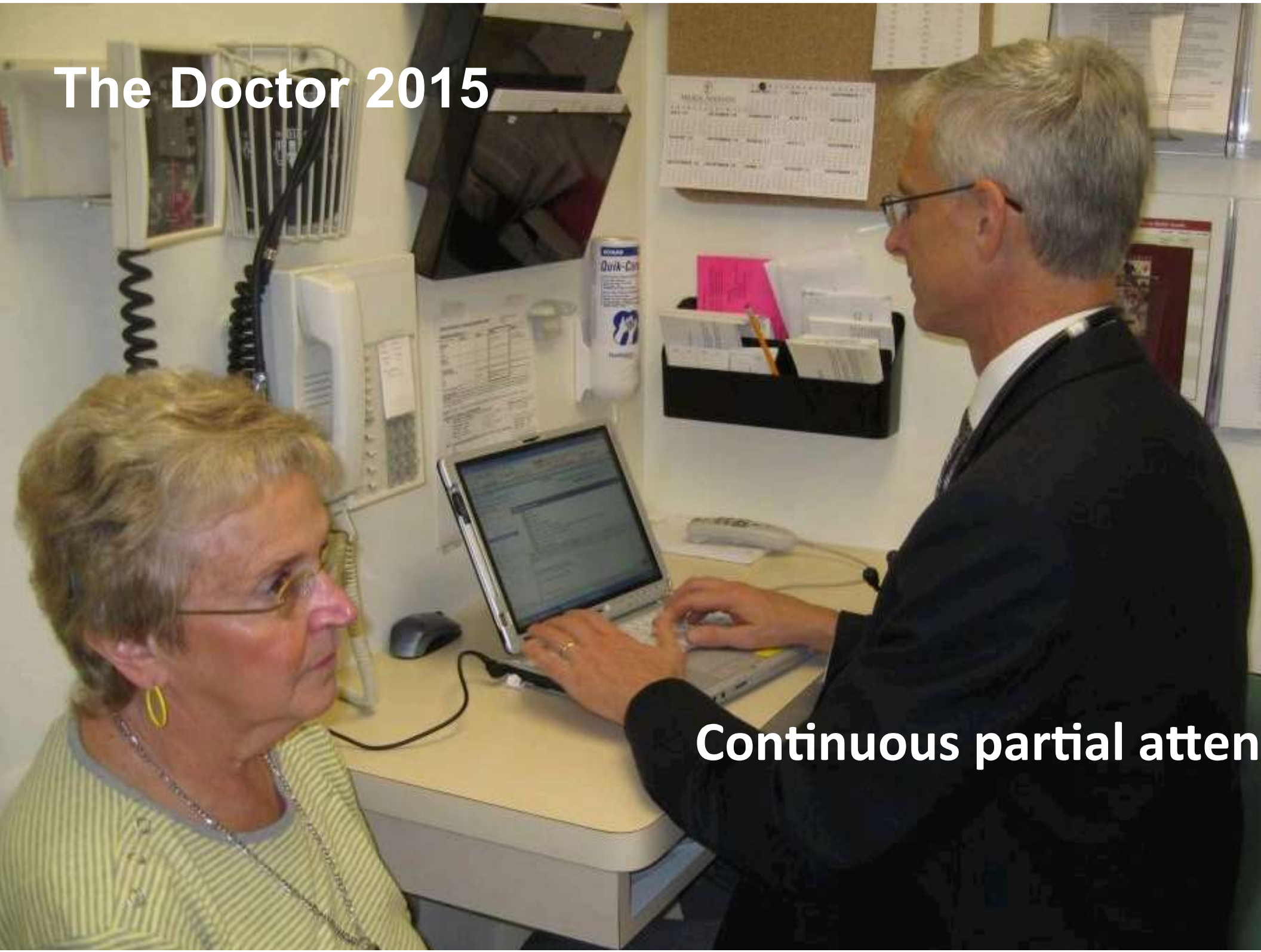
On a more personal level

- Unrealistic **expectations** or difficulty reaching **goals**
  - Income
  - Family time
  - Exercise. recreation and relaxation
  - Healthy eating
  - Professional development
- "**Emotional bank account**" balance is low
  - Relationships (spouse, family, friends, colleagues)
  - Not enough time for reflection and spirituality
  - Often giving more than receiving (physically, emotionally and spiritually)
- Everyone thinks: "**You are a doctor…you must be OK**" and therefore less in need of nurturing and support

Looking for balance




The Doctor 1891 Fildes
Undivided attention


The Doctor 2015
Continuous partial atten

Getting at the root cause of practice blues

- **Externalities** — 20%
  - Insurance hassles and payment rules
  - EHR functionalities not optimal
  - Medical liability
- **Internal operations in the practice** — 80%
  - The hero model still predominates
  - Team approach is underutilized
  - Too much reliance on memory and not enough use of systems to enhance reliability and consistency of care
  - Sub-optimal use of health information technology and connectedness
  - A “culture of improvement” and team-based positive approach to problem solving is weak or non-existent

In the end…

“Happiness is a decision you make every morning”

If you can’t manage to make that choice anymore, then it is time to change something!

Questions and Discussion

Concrete **STEPS Forward**

Practical, manageable advice on practice redesign and transformation of your systems and workflow.

Qualities of successful practices

- Workflow Redesign
  - Improve quality
  - Relationship with team and patients
  - Plan ahead
- Communication
  - Among team members
  - Physicians ⟷ administration

Practice transformation strategies

- Prescription management
- Pre-visit planning
- Expanded rooming and discharge
- Huddles and meetings

Synchronized prescription renewal

Toolkit

Annual prescription renewals

- Physician time
  - 0.5 hour/day
- Nursing time
  - 1 hour per day per physician
  - ↑ patient adherence
- Time saved ↑ patient access

Pre-visit planning

Toolkit

Pre-visit planning

- Pre-visit laboratory testing
- Visit planner
- Visit prep checklist
- Pre-appointment questionnaire

Pre-visit laboratory testing

- Majority of lab ahead
- Quality
  - In-person, shared decision making
- Efficiency
  - Close the loop of care
  - 4 hr clinic → 2 hrs saved
- Safety
  - ↓ missing/overlooked information
  - ↑ patient/family access

Pre-visit laboratory testing

Case study from MGH

- 89% ↓ phone calls ($p<0.001$)
- 85% ↓ letters ($p<0.0001$)
- ↑ patient satisfaction
- Save $24 per visit

Source: Crocker B, Lewandrowski E, Lewandrowski N, Gregory K, Lewandrowski K. Patient Satisfaction With Point-of-Care Laboratory Testing: Report of a Quality Improvement Program in an Ambulatory Practice of an Academic Medical Center. *Clin Chem Acta* 2013; 424:8-12.http://ajcp.ascpjournals.org/content/142/5/640.abstract

Visit Planner: "*Next appointment starts today*"

Visit prep checklist

Preventive screening	Due	Up to date	N/A	Target population and recommendation
PAP	☐	☐	☐	Age 21 to 65 years Every 3 years if no history of abnormal PAPs (or every 5 years if over 30 and PAP and HPV-negative)
Mammogram	☐	☐	☐	Age 50 to 75 years Every 1 to 2 years; or for those 40 to 50 and >75 screening is optional
Colonoscopy	☐	☐	☐	Age 50 to 75 years Every 10 years from (more frequent with history of colon polyp or family history of colon cancer)
Bone Density Scan (DEXA)	☐	☐	☐	Age 65 years--women Every 10 years if normal; every 5 years if symptoms of osteopenia exist
Abdominal aortic aneurysm	☐	☐	☐	Age 65 to 75 years—men who have ever smoked One-time screening
Visual acuity	☐	☐	☐	Age >65 years (new Medicare enrolees) Can be completed during the Welcome to Medicare visit
Glaucoma screen	☐	☐	☐	Age >65 years Annually

Immunization	Due	Up to date	N/A	Target population and recommendation
Tdap vaccine	☐	☐	☐	Age >19 years Administer Tdap once; boost with Td every 10 years
Influenza vaccine	☐	☐	☐	Age >6 months Annually
Shingles vaccine	☐	☐	☐	Age >60 years Option if >50 years
Pneumococcal vaccine (PCV13 or PPSV23)	☐	☐	☐	Age >65 years • PCV13 now, followed by PPSV23 six to 12 months later • If already received PPSV23, wait at least one year before giving PCV13 Patients age 18 to 65 with a chronic* or immunocompromising condition may also need a pneumococcal vaccine.

Pre-appointment questionnaire

- Systems approach
  - Update PFSH
  - Complete ROS
  - Behavior items
    - Exercise
    - Smoking
    - Alcohol
  - Patient sets agenda for visit with nurse/MA
- Annual Wellness Visit
  - Mirrors EHR
- Future
  - Patient portal
  - Kiosk

Expanded rooming and discharge protocols

Toolkit

Expanded rooming process

Rooming

- Vitals
- Medication reconciliation
- Standing orders
  - Immunizations
  - Preventive testing
  - Diabetic foot exam
- AWV
- Initial review of lab results
- Set visit agenda with patient
- Mini huddle

Discharge

- Order entry
- Prescriptions
- Education, reinforce physician portion of visit
- Review clinical summary
- Standardized, predictable

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Huddles & team meetings

Toolkit

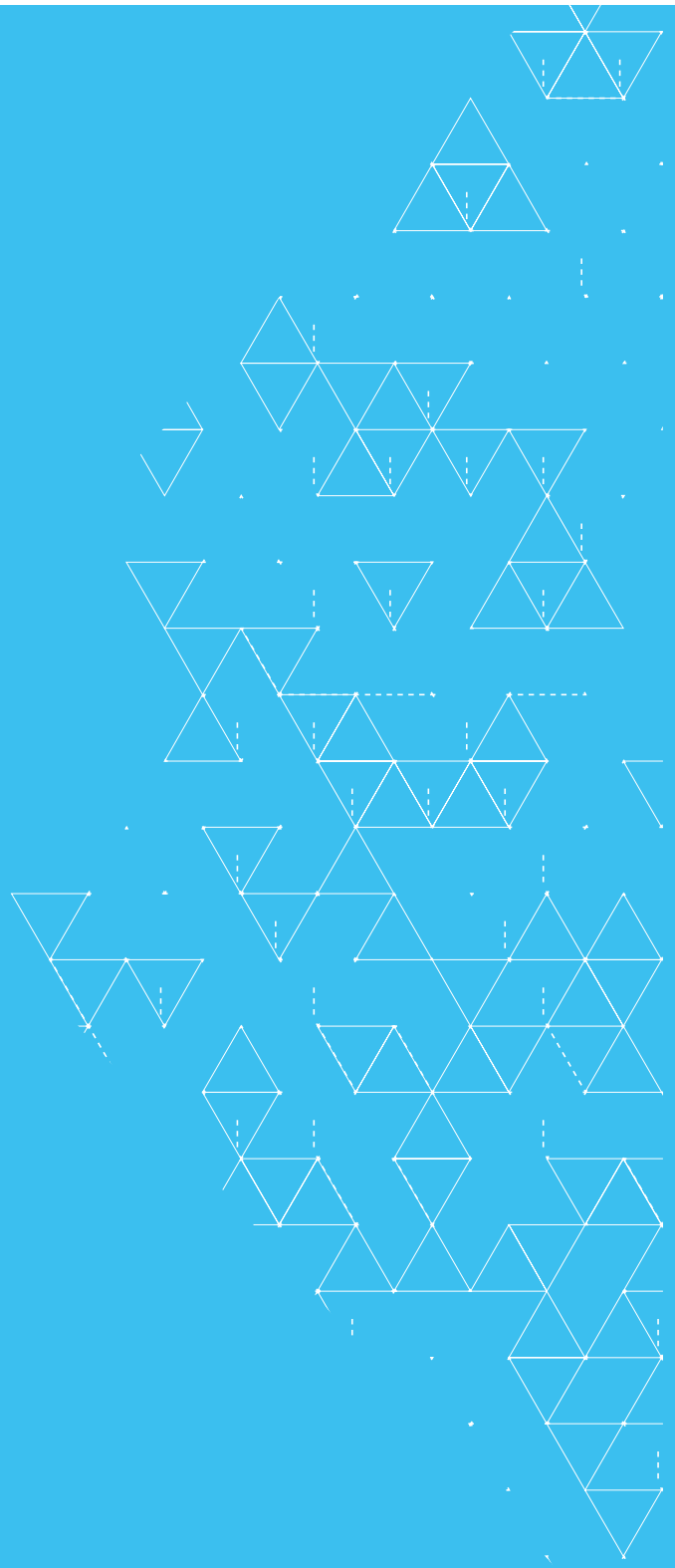
Huddles

- 10-15 minute check-in before each clinic session begins
- Team discusses patients and focuses on issues that may come up
- Discussion of scheduling opportunities (e.g., available walk-in appointments or recent cancelations)

Team meetings

- 1 hour gathering every 1-2 weeks
- Dedicated time to discuss the status of projects, identify opportunities for improvement within the practice, conduct education and build a strong culture
- Team-building opportunity
- Rotating roles enables everyone to have a voice and collaborate with colleagues differently than they may during the clinic session

Demonstration:
www.stepsforward.org



Taking action

Key steps

- Assess staffing in relation to new approach
- Train staff for new roles and responsibilities
- Partner with administrative leaders
  - Policies and procedures
  - Re-write job descriptions
  - Identify training opportunities
  - Create plan for pilot or roll-out
  - Manage team, patient and other physician expectations

Take home messages

It's all about:

- Leadership
- Teamwork
- Communication
- Metrics

Thank you!

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STEPSForward.org